

<i>SERFF Tracking Number:</i>	<i>PRLF-126079005</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Principal Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41963</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001C Any Size Group - Other</i>
<i>Product Name:</i>	<i>GC 5000, et al</i>		
<i>Project Name/Number:</i>	<i>Lg Employer MHAD/</i>		

## Filing at a Glance

Company: Principal Life Insurance Company

Product Name: GC 5000, et al

TOI: H16G Group Health - Major Medical

Sub-TOI: H16G.001C Any Size Group - Other

Filing Type: Form

SERFF Tr Num: PRLF-126079005

SERFF Status: Closed

Co Tr Num:

Co Status:

Authors: Bonnie Blue, Tracy Israel

Date Submitted: 03/24/2009

State: ArkansasLH

State Tr Num: 41963

State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Disposition Date: 03/25/2009

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Lg Employer MHAD

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 03/25/2009

Deemer Date:

Filing Description:

RE Group Accident and Health Forms

Group Medical Expense Insurance Forms

- Policy Form Series GC 5000, et al – Policy Insert Pages
- Booklet-Certificate Form Series GH 100A, et al – Booklet-Certificate Insert Pages

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: This is not being filed in our state of domicile, Iowa.

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer

Explanation for Other Group Market Type:

State Status Changed: 03/25/2009

Corresponding Filing Tracking Number:

The above referenced forms are enclosed for your review and approval. The revised forms are for use with our Group

*SERFF Tracking Number: PRLF-126079005 State: Arkansas*  
*Filing Company: Principal Life Insurance Company State Tracking Number: 41963*  
*Company Tracking Number:*  
*TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other*  
*Product Name: GC 5000, et al*  
*Project Name/Number: Lg Employer MHAD/*

Medical Expense Insurance Policy series, GC 5000, et al and the corresponding booklet-certificate series GH 100 A, et al which were originally filed and approved by your department on November 24, 1997 with subsequent revisions also filed and approved.

We are revising our group medical product to change the mental health and alcohol or drug abuse benefits for large employer groups from their current benefits to benefits that are covered the same as for any other covered treatment or service. Due to this revision, we are referring to these benefits as Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services for large employer groups throughout the policy and booklet. The mental health and alcohol or drug abuse benefits for small employer groups are not changing and we are continuing to refer to these benefits as Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services for small employer groups throughout the policy and booklet.

At this time, we are using form numbers GC 5001-2, GC 5002-3, GH 104 A-3, GH 104 B-4, and GH 136 A (MED)-3 which were approved by your department on August 27, 2004 and form number GH 104 B (HDHP)-1 which was approved by your department on November 8, 2004. Form numbers GC 5001-3, GC 5002-4, GH 104 A-4, GH 104 B (HDHP)-2, GH 104 B-5, and GH 136 A (MED)-4 which were approved by your department on September 27, 2005 have not been implemented yet and at this time, we have no immediate plans to do so.

All text revisions are shown in italics in the enclosed documents.

To assist in your review of this filing, we are attaching a Statement of Variability for the variables included on each policy form.

Thank you for your consideration of this submission. All required certification forms are enclosed. The applicable Filing Fee is also enclosed.

If you have any questions on any of the attached materials, please feel free to contact me by fax, e-mail or at the toll-free number shown below.

## **Company and Contact**

SERFF Tracking Number: PRLF-126079005 State: Arkansas  
Filing Company: Principal Life Insurance Company State Tracking Number: 41963  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other  
Product Name: GC 5000, et al  
Project Name/Number: Lg Employer MHAD/

### Filing Contact Information

Tracy Israel, State/Federal Compliance Analyst Israel.Tracy@principal.com  
711 High St. (800) 986-3343 [Phone]  
Des Moines, IA 50392-0002 (515) 246-2491[FAX]

### Filing Company Information

Principal Life Insurance Company CoCode: 61271 State of Domicile: Iowa  
711 High Street Group Code: 332 Company Type: Life & Health  
Des Moines, IA 50392-0002 Group Name: State ID Number:  
(800) 986-3343 ext. [Phone] FEIN Number: 42-0127290  
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### Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation:  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Principal Life Insurance Company	\$50.00	03/24/2009	26641348

<i>SERFF Tracking Number:</i>	<i>PRLF-126079005</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Principal Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41963</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001C Any Size Group - Other</i>
<i>Product Name:</i>	<i>GC 5000, et al</i>		
<i>Project Name/Number:</i>	<i>Lg Employer MHAD/</i>		

## Correspondence Summary

### Dispositions

<b>Status</b>	<b>Created By</b>	<b>Created On</b>	<b>Date Submitted</b>
Approved-Closed	Rosalind Minor	03/25/2009	03/25/2009

<i>SERFF Tracking Number:</i>	<i>PRLF-126079005</i>	<i>State:</i>	<i>Arkansas</i>
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<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001C Any Size Group - Other</i>
<i>Product Name:</i>	<i>GC 5000, et al</i>		
<i>Project Name/Number:</i>	<i>Lg Employer MHAD/</i>		

## Disposition

Disposition Date: 03/25/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: PRLF-126079005 State: Arkansas  
Filing Company: Principal Life Insurance Company State Tracking Number: 41963  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other  
Product Name: GC 5000, et al  
Project Name/Number: Lg Employer MHAD/

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Form	Table of Contents	Approved-Closed	Yes
Form	Part I - Definitions	Approved-Closed	Yes
Form	Part IV - Benefits - Section A (4) Comprehensive Medical Expense Insurance (PPO) - [Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services][Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]	Approved-Closed	Yes
Form	Part IV - Benefits - Section A (4) Comprehensive Medical Expense Insurance (PPO) - [Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services][Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]	Approved-Closed	Yes
Form	Part IV - Benefits - Section B (4) Comprehensive Medical Expense Insurance - [Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services][Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]	Approved-Closed	Yes
Form	Summary of Benefits (Indemnity)	Approved-Closed	Yes
Form	Summary of Benefits (PPO)	Approved-Closed	Yes
Form	Summary of Benefits (PPO)	Approved-Closed	Yes
Form	Description of Benefits - [Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services][Mental Health, Behavioral,	Approved-Closed	Yes

SERFF Tracking Number:	PRLF-126079005	State:	Arkansas
Filing Company:	Principal Life Insurance Company	State Tracking Number:	41963
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TOI:	H16G Group Health - Major Medical	Sub-TOI:	H16G.001C Any Size Group - Other
Product Name:	GC 5000, et al		
Project Name/Number:	Lg Employer MHAD/		

Alcohol or Drug Abuse Treatment  
Services]

**Form**

Description of Benefits - [Mental Health or Approved-Closed Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services][Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]

Yes

**Form**

Description of Benefits - [Mental Health or Approved-Closed Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services][Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]

Yes

**Form**

Definitions Approved-Closed Yes

SERFF Tracking Number: PRLF-126079005 State: Arkansas  
Filing Company: Principal Life Insurance Company State Tracking Number: 41963  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other  
Product Name: GC 5000, et al  
Project Name/Number: Lg Employer MHAD/

## Form Schedule

**Lead Form Number:** GC 5001-3

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	GC 5001 (R)	Policy/Cont Table of Contents ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: GC 5001-2 Previous Filing #:		GC 5001 (R).pdf
Approved-Closed	GC 5002 (R)	Policy/Cont Part I - Definitions ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Revised	Replaced Form #: GC 5002-3 Previous Filing #:		GC 5002 (R).pdf
Approved-Closed	GC 5014 C (HDHP) AR-1	Policy/Cont Part IV - Benefits - ract/Fratern Section A (4) al Comprehensive Certificate: Medical Expense Amendmen Insurance (PPO) - t, Insert [Mental Health or Page, Behavioral Treatment Endorseme Services and Alcohol nt or Rider or Drug Abuse Treatment Services][Mental Health, Behavioral, Alcohol or Drug Abuse Treatment	Revised	Replaced Form #: GC 5014 C (HDHP) AR Previous Filing #:		GC 5014 C (HDHP) AR-1.pdf



SERFF Tracking Number: PRLF-126079005 State: Arkansas  
Filing Company: Principal Life Insurance Company State Tracking Number: 41963  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other  
Product Name: GC 5000, et al  
Project Name/Number: Lg Employer MHAD/

Services]

Approved- GC 5014 C Policy/Cont Part IV - Benefits - Revised Replaced Form #: GC 5014 C  
Closed AR-1 ract/Fratern Section A (4) GC 5014 C AR AR-1.pdf  
al Comprehensive Previous Filing #:

Certificate: Medical Expense  
Amendmen Insurance (PPO) -  
t, Insert [Mental Health or  
Page, Behavioral Treatment  
Endorseme Services and Alcohol  
nt or Rider or Drug Abuse  
Treatment  
Services][Mental  
Health, Behavioral,  
Alcohol or Drug  
Abuse Treatment  
Services]

Approved- GC 5013 C Policy/Cont Part IV - Benefits - Revised Replaced Form #: GC 5013 C  
Closed AR-1 ract/Fratern Section B (4) GC 5013 C AR AR-1.pdf  
al Comprehensive Previous Filing #:

Certificate: Medical Expense  
Amendmen Insurance - [Mental  
t, Insert Health or Behavioral  
Page, Treatment Services  
Endorseme and Alcohol or Drug  
nt or Rider Abuse Treatment  
Services][Mental  
Health, Behavioral,  
Alcohol or Drug  
Abuse Treatment  
Services]

Approved- GH 104 A Certificate Summary of Benefits Revised Replaced Form #: GH 104 A  
Closed (R) Amendmen (Indemnity) GH 104 A-3 (R).pdf  
t, Insert Previous Filing #:

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Approved- GH 104 B Certificate Summary of Benefits Revised Replaced Form #: GH 104 B  
Closed (HDHP) (R) Amendmen (PPO) GH 104 B (HDHP)-1 (HDHP)

SERFF Tracking Number:	PRLF-126079005	State:	Arkansas
Filing Company:	Principal Life Insurance Company	State Tracking Number:	41963
Company Tracking Number:			
TOI:	H16G Group Health - Major Medical	Sub-TOI:	H16G.001C Any Size Group - Other
Product Name:	GC 5000, et al		
Project Name/Number:	Lg Employer MHAD/		
	t, Insert	Previous Filing #:	(R).pdf
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Approved- GH 104 B	Certificate Summary of Benefits Revised	Replaced Form #:	GH 104 B
Closed (R)	Amendmen (PPO)	GH 104 B-4	(R).pdf
	t, Insert	Previous Filing #:	
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Approved- GH 411 B	Certificate Description of	Replaced Form #:	GH 411 B
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AR-1	t, Insert Health or Behavioral	AR	1.pdf
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	Services][Mental		
	Health, Behavioral,		
	Alcohol or Drug		
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	Services][Mental		
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Approved- GH 412 B	Certificate Description of	Replaced Form #:	GH 412 B
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<i>SERFF Tracking Number:</i>	<i>PRLF-126079005</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Principal Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41963</i>
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<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001C Any Size Group - Other</i>
<i>Product Name:</i>	<i>GC 5000, et al</i>		
<i>Project Name/Number:</i>	<i>Lg Employer MHAD/</i>		

Services][Mental  
Health, Behavioral,  
Alcohol or Drug  
Abuse Treatment  
Services]

Approved- GH 136 A Certificate Definitions	Revised	Replaced Form #:	GH 136 A
Closed (MED) (R) Amendmen		GH 136 A (MED)-3	(MED) (R).pdf
t, Insert		Previous Filing #:	
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### **Section B (3) – Comprehensive Medical Expense Insurance - Covered Charges**

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[1] **Section B (4) – Comprehensive Medical Expense Insurance – /Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services/**  
[2] ***[Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]***

[1] */Payment Conditions – Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services..... Article 1]*  
[2] *[Payment Conditions – Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services..... Article 1]*

### **Section B (5) – Comprehensive Medical Expense Insurance - Transplant Services**

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## **PART IV – BENEFITS (Cont.)**

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**[PART V - PARTICIPATING UNIT PROVISIONS**

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**Section B - Participating Unit**

**Section C - Member Insurance**

**Section D - Administration**

**Section E - Termination**

**[Section F - List of Participating Units]]**

## **PART I - DEFINITIONS**

When used in this Group Policy, the terms listed below will mean:

### **[1] [Alcohol or Drug Abuse Treatment Services]**

Treatment or Service provided to alter a person's behavior, regardless of the cause of that behavior, including, but not limited to: individual, family or group psychotherapy; psychiatric diagnostic interview or examinations; behavior modification; alcohol or drug abuse medication management; alcohol or drug abuse rehabilitation or counseling services; [biofeedback,] or milieu or other therapies (physical, occupational or speech therapy), used to diagnose or treat alcohol or drug abuse problems.]

### **Ambulatory Surgery Center**

A facility designed to provide surgical care which does not require Hospital Inpatient Confinement but is at a level above what is available in a Physician's office or clinic. An Ambulatory Surgery Center:

- a. is licensed by the proper authority of the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and
- b. provides Physician services and full-time skilled nursing services directed by a licensed registered nurse (R.N.) whenever a patient is in the facility; and
- c. does not provide the services or other accommodations for Hospital Inpatient Confinement; and
- d. is not a facility used as an office or clinic for the private practice of a Physician or other professional providers.

### **Average Wholesale Price (AWP)**

The published cost of a drug product to the wholesaler.

### **Birthing Center**

A freestanding facility that is licensed by the proper authority of the state in which it is located and that:

- a. provides prenatal care, delivery, and immediate postpartum care; and
- b. operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and
- c. has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and

- d. provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and
- e. has a Written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with Written procedures for such transfer being displayed and staff members being aware of such procedures.

### **Community Mental Health Center**

[1] A community or county mental health facility that is licensed by the proper authority of the state in  
[2] which it is located, and is primarily engaged in providing outpatient [Mental Health or Behavioral Treatment Services][*Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services*].

### **[Copayment; Copay**

A specified dollar amount that must be paid by a Member [or Dependent] each time certain or specified services are rendered. [In no event will the Copay amount exceed:

- a. for services provided by PPO Providers, the negotiated fee; and
- b. for services provided by Non-PPO Providers, the actual cost charged to the Member [or Dependent].]

### **Cosmetic Treatment and Services**

Treatment or Services to change:

- a. the texture or appearance of the skin; or
- b. the relative size or position of any part of the body;

when such Treatment or Service is performed primarily for psychological purposes or is not needed to correct or improve a bodily function. Cosmetic Treatment and Services include, but are not limited to, surgery, pharmacological regimens and all related charges.

### **[Covered Charges] [Medically Necessary Care]**

A Treatment or Service is considered to be [a Covered Charge][Medically Necessary Care] if the Treatment or Service is:

- a. prescribed by a Physician and required for the screening, diagnosis or treatment of a medical condition;
- b. consistent with the diagnosis or symptoms;
- c. not excessive in scope, duration, intensity or quantity;
- d. the most appropriate level of services or supplies that can safely be provided; and
- e. determined by The Principal to be Generally Accepted.

## **Creditable Coverage**

With respect to an individual, coverage of the individual under any of the following:

- a. a Group Health Plan, as defined in this PART I;
- b. Health Insurance Coverage, as defined in this PART I;
- c. Medicare (Part A or Part B of Title XVIII of the Social Security Act);
- d. Medicaid (Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928);
- e. TRICARE (Chapter 55 of Title 10, United States Code);
- f. a medical care program of the Indian Health Service or of a tribal organization;
- g. a state health benefits risk pool;
- h. a health benefit plan for government employees (Chapter 89 of Title 5, United States Code);
- i. a public health plan;
- j. a health benefit plan provided under the Peace Corp Act;
- k. any other similar coverage permitted under state or federal law or regulations.

Creditable Coverage does not include coverage consisting solely of coverage of Excepted Benefits. For this purpose, "Excepted Benefits" mean benefits or coverage under one or more (or any combination) of the following:

- a. coverage only for accident (including accidental death and dismemberment);
- b. disability income insurance;
- c. liability insurance, including general liability insurance and automobile liability insurance;
- d. coverage issued as a supplement to liability insurance;
- e. Workers' Compensation or similar insurance;
- f. automobile medical payment insurance;
- g. credit-only insurance (for example, mortgage insurance);
- h. coverage for on-site medical clinics;
- i. other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits;



- j. the following benefits, if offered separately from medical expense benefits (provided under a separate policy, certificate or contract of insurance, or otherwise not an integral part of the plan):
  - limited scope dental or vision benefits;
  - benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
  - other similar limited benefits;
- k. the following benefits, if offered as independent, noncoordinated benefits:
  - coverage only for a specified disease or illness;
  - hospital indemnity or other fixed indemnity insurance;
- l. the following benefits, if offered as a separate insurance policy:
  - Medicare Supplement insurance;
  - coverage supplemental to TRICARE;
  - similar supplemental coverage provided to coverage under a Group Health Plan.

### **Custodial Care**

Assistance with meeting personal needs or the Activities of Daily Living.

For this purpose, “Activities of Daily Living” means activities that do not require the services of a Physician, registered nurse (R.N.), licensed practical nurse (L.P.N.), chiropractor, physical therapist, occupational therapist, speech therapist, or other health care professional including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination and taking medications.

### **Date of Issue**

The date this Group Policy is placed in force: [January 1, 2005].

### **Deductible; Deductible Amount**

A specified dollar amount of Covered Charges that must be incurred by the Member [or Dependent] before benefits will be payable under this Group Policy for all or part of the remaining Covered Charges during the calendar year.

### **Dental Services**

Any Treatment or Service provided to diagnose, prevent, or correct:

- a. periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); or
- b. malocclusion (abnormal positioning or relationship of the teeth); or
- c. ailments or defects of the teeth and supporting tissue and bone (excluding [impacted teeth and]

appliances used to close an acquired or congenital opening. However, the term Dental Services will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance).

### **[Dependent**

- a. A Member's spouse, if that spouse:
  - (1) is not in the Armed Forces of any country;[ and
  - (2) is not insured under this Group Policy as a Member.]
- b. A Member's Dependent Child (or Children) as defined below][.]; and
- [c. A Member's Domestic Partner, if the Member and the Domestic Partner complete and submit a Declaration of Domestic Partnership which is approved by The Principal.]

### **[Dependent Child; Dependent Children**

- a. A Member's natural or legally adopted child, if that child:
  - (1) is not married; and
  - (2) is not in the Armed Forces of any country; and
  - (3) is not insured under this Group Policy as a Member; and
  - (4) is less than 19 years of age.

A newly adopted child will be considered a Dependent Child from the date of Placement with the Member for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a Dependent Child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- b. A Member's stepchild, if that child:
  - (1) meets the requirements in a. (1), (2), (3), and (4) above; and
  - (2) receives principal support from the Member.
- c. A Member's foster child, if that child:
  - (1) meets the requirements in a. (1), (2), (3), and (4) above; and
  - (2) lives with the Member; and
  - (3) receives principal support from the Member; and
  - (4) is approved in Writing by The Principal as a Dependent Child.
- [d. A Member's child 19 years but less than [25] years of age who otherwise qualifies under a., b. or c. above, if that child receives principal support from the Member and is a Full-Time Student, as defined in this PART I.]
- [e. A Member's child 19 years but less than [25] years of age, if that child is a Mormon missionary [for a period of [two years] or less]; and
  - (1) otherwise qualifies under a., b., or c. above; and
  - (2) receives principal support from the Member.]

- [f. A Domestic Partner's child who otherwise qualifies under a., c., d. or e. above or if the Member or Domestic Partner has been appointed the child's guardian under a valid court order.]

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to this Group Policy, provided the child meets this Group Policy's definition of a Dependent Child.]

#### **[Developmental Disability**

A Dependent Child's substantial handicap which:

- a. results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- c. is diagnosed by a Physician as a permanent or long-term continuing condition.]

#### **[Domestic Partner**

A Member's [opposite sex or] same sex life partner, provided:

- a. the partner is not in the armed forces of any country; and
- b. the partner is not covered under this Group Policy as a Member; and
- c. the partner is at least 18 years of age; and
- d. neither the partner nor the Member is married to other persons; and
- e. neither the partner nor the Member has had another Domestic Partner in the 6-month period preceding the date of the Signed Declaration of Domestic Partnership; and
- f. the partner is not a blood relative of the Member; and
- g. the partner and the Member have shared the same residence for at least [six] consecutive months and continue to do so; and
- h. the partner and the Member are each other's sole life partner and intend to remain so indefinitely; and
- i. the partner and the Member are jointly responsible for each other's financial welfare; and
- j. the partner and the Member are not in their relationship solely for the purpose of obtaining insurance coverage.]

## **Experimental or Investigational Measures**

Any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine.

## **Full-Time Employee**

Any person who is regularly scheduled to work for the [Policyholder] [or a] [Participating Unit] for at least [30 hours] a week. The employee must be compensated by the [Policyholder] [or a] [Participating Unit] and either the employer or employee must be able to show taxable income on federal or state tax forms. Work must be at the [Policyholder's] [or a] [Participating Unit's] usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

An owner, proprietor or partner of the [Policyholder][or a][Participating Unit's] business will be deemed to be an eligible employee for purposes of this Group Policy, provided he or she is regularly scheduled to work for the [Policyholder][Participating Unit] for at least [30 hours] a week and otherwise meets the definition of Full-Time Employee.

## **[Full-Time Student**

A Member's Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- a. attends school on a full-time basis, as determined by the school's criteria; and
- b. is dependent on the Member for principal support.]

## **Generally Accepted**

Treatment or Service for the particular sickness or injury which is the subject of the claim that:

- a. has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- b. is in general use in the relevant medical community; and
- c. is not under scientific testing or research.

## **Group Health Plan**

An employee welfare benefit plan, as defined in ERISA, to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

## **Group Policy**

The policy of group insurance issued to the Policyholder by The Principal which describes benefits and provisions for Members [and Dependents].

**Health Care Extender**

A health care provider who assists in the delivery of covered medical services under the direction and supervision of a Physician.

"Direction and supervision" means the Physician co-signs any progress notes Written by the Health Care Extender; or there is a legal agreement that places overall responsibility for the Health Care Extender's services on the Physician.

**Health Insurance Coverage**

Benefits consisting of medical care provided directly, through insurance or reimbursement or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or Health Maintenance Organization (HMO) contract, offered by an insurance company, insurance service, or insurance organization (including an HMO) licensed to engage in the business of insurance and subject to state law which regulates insurance.

**Health Maintenance Organization (HMO)**

An entity that is:

- a. A federally qualified Health Maintenance Organization as defined by federal law; or
- b. An organization recognized under state law as a Health Maintenance Organization; or
- c. A similar organization regulated under state law for solvency in the same manner and to the same extent as such a Health Maintenance Organization.

**HMO Affiliation Period**

A period of time which, under the terms of the Health Insurance Coverage offered by a Health Maintenance Organization (HMO), must expire before an individual's coverage becomes effective.

**Home Health Aide**

A person, other than a licensed registered nurse (R.N.), who provides medical or therapeutic care under the supervision of a Home Health Care Agency.

**Home Health Care Agency**

A Hospital, agency, or other service that is certified by the proper authority of the state in which it is located to provide home health care.

**Home Health Care Plan**

A program of home care that:

- a. is required as the result of a sickness or injury; and
- b. prevents, delays or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and
- c. is documented in a Written plan of care; and
- d. is prescribed by the attending Physician; and
- e. is preapproved by The Principal.

**Home Infusion Therapy Services**

Treatment or Service required for the administration of intravenous drugs or solutions, which:

- a. is required as a result of a sickness or injury; and
- b. prevents, delays, or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and
- c. is documented in a Written plan of care; and
- d. is prescribed by the attending Physician; and
- e. is preapproved by The Principal.

**Hospice**

A facility, agency, or service that:

- a. is licensed by the proper authority of the state in which it is located to establish and manage Hospice Care Programs; and
- b. arranges, coordinates, and provides Hospice Care Services for dying individuals and their families; and
- c. maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

## **Hospice Care Program**

A program that furnishes palliative or supportive care focused on comfort and not cure and that is:

- a. managed by a Hospice; and
- b. established jointly by a Hospice, a Hospice Care Team, and an attending Physician;

to meet the special physical, psychological, and spiritual needs of dying individuals and their families.

## **Hospice Care Team**

A group that provides coordinated Hospice Care Services and normally includes:

- a. a Physician;
- b. a patient care coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician);
- c. a nurse;
- d. a mental health specialist;
- e. a social worker;
- f. a chaplain; and
- g. lay volunteers.

## **Hospital**

An institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

- [1] For the purpose of [Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse  
[2] Treatment Services]/[*Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services*], the definition of "Hospital" will include each of the following facilities provided it is licensed by the proper authority of the state in which it is located:

- a. a Psychiatric Hospital; and
- b. an Inpatient Alcohol or Drug Abuse Treatment Facility; and
- c. any other facility required by state law to be recognized as a treatment facility under this Group Policy.

### **Hospital Inpatient Confined; Hospital Inpatient Confinement**

Any period of Treatment or Service in a Hospital in excess of twenty-three consecutive hours for any cause. A [Hospital Admission Review] [Prenotification] as defined in PART IV, Section B1 [(1)][(1A)], is required for Hospital Inpatient Confinements.

### **Hospital Inpatient Confinement Charges**

Covered Charges by a Hospital for room, board, [and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia] provided while a person is Hospital Inpatient Confined.

### **Hospital Room Maximum**

Covered Charges by a Hospital for room and board while confined in a private room up to:

- a. the Hospital's most frequent semiprivate room rate, if the Hospital has semiprivate rooms; or
- b. the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

### **Immediate Family**

[A Member's Domestic Partner or] A Member's [or a Dependent's] spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

### **Inpatient Alcohol or Drug Abuse Treatment Facility**

An institution that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing alcohol or drug detoxification or rehabilitation treatment services; and

- a. is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.); and
- b. provides 24-hour a day on-site nursing care by licensed registered nurses (R.N.).

### **Insurance Month**

[Calendar month.] [The first insurance month begins on [August 15, 2005], and ends on [September 30, 2006].] [The period of time from the [15th] day of any month to the [14th] day of the next month.]



## **Medical Emergency**

Any Treatment or Service that The Principal determines to be due to the sudden onset of severe medical symptoms that:

- a. could not have been reasonably anticipated; and
- b. require immediate medical care.

## **[Member**

[Any person who is a Full-Time Employee of the [Policyholder] [or a] [Participating Unit].

[Member will also include any such person who retires on or after [January 1, 1998 and maintains continuous coverage with the [Policyholder] [or a] [Participating Unit] under this Group Policy.]

## **[1] [Mental Health or Behavioral Treatment Services**

Treatment or Service provided to alter a person's behavior, regardless of the cause of that behavior, including, but not limited to: individual, family or group psychotherapy; psychological testing; electroconvulsive therapy; psychiatric diagnostic interviews or examinations; behavior modification; psychiatric medication management; [hypnotherapy;] narcosynthesis; [biofeedback,] or milieu or other therapies (physical, occupational or speech therapy), used to diagnose or treat mental health or behavioral problems.]

## **[2] *[Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services***

*Treatment or Service provided to alter a person's behavior, regardless of the cause of that behavior, including, but not limited to: individual, family or group psychotherapy; psychological testing; electroconvulsive therapy; psychiatric diagnostic interviews or examinations; behavior modification; psychiatric, alcohol or drug abuse medication management; alcohol or drug abuse rehabilitation or counseling services; [hypnotherapy]; narcosynthesis; [biofeedback], milieu or other therapies (physical, occupational or speech therapy) used to diagnose or treat mental health, behavioral, alcohol or drug abuse problems.]*

## **[Non-Preferred Provider/Non-PPO Provider**

A Hospital, Physician, or other provider not contracted with the preferred provider organization (PPO) network identified by The Principal to this Group Policy.]

## **Outpatient Alcohol or Drug Abuse Treatment Facility**

A facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient alcohol or drug abuse treatment services.

## **[Participating Unit**

Any entity meeting the requirements outlined in PART II and PART V of this Group Policy.]

### **[Period of Confinement]**

A period of Hospital Inpatient Confinement. For the purposes of applying the Hospital charges Copay amount for each admission, two or more periods of Hospital Inpatient Confinement will be considered one period of confinement unless caused by an unrelated sickness or injury, or unless separated by [30 consecutive] days or more.]

### **[Physical Handicap]**

A Dependent Child's substantial physical or mental impairment which:

- a. results from injury, accident, congenital defect, or sickness; and
- b. is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.]

### **Physician**

- a. A licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or
- b. any other licensed health care practitioner that state law requires be recognized as a Physician under this Group Policy.

Whether or not required by state law, the following licensed or certified health care practitioners will be recognized, on the same basis as a Physician, for Covered Charges of services performed within the scope of their license: audiologist, chiropractor, dentist, [genetic counselor,] occupational therapist, optometrist, physician's assistant, physical therapist, podiatrist, psychologist, social worker, and speech pathologist.

### **Physician Visit**

A face-to-face meeting [or an approved form of on-line consultation] between a Physician or the Physician's staff and a patient for the purpose of medical Treatment or Service.

### **[Physician Visit Charges]**

Covered Charges for Treatment or Service furnished at a Physician's office or clinic. Such services include charges for: dressings; [supplies;] [equipment;] injections; anesthesia; take-home drugs; blood; blood plasma; x-ray and laboratory examinations; x-ray, radium, and radioactive isotope therapy; and routine physical examinations [; but do not include outpatient, clinic or office-based surgery, magnetic resonance imaging (MRIs); computerized axial tomography (CATs); positron emission tomography (PETs) and single photon emission computerized tomography (SPECTs) or other similar imaging tests].

### **Placement for Adoption; Placement**

The assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

## **Policy Anniversary**

[January 1, 2006 and the same day of each following year]. [The same day of each calendar year of the Date of Issue of this Group Policy;] [but for any Participating Unit having its own Policy Anniversary, it will be the same date of each calendar year as that on which the Participating Unit's coverage under this Group Policy was made effective.]

## **Policyholder**

The entity to whom this Group Policy is issued (see Title Page).

## **[Preferred Provider/PPO Provider**

A Hospital, Physician, or other provider contracted with a preferred provider organization (PPO) network identified by The Principal to this Group Policy.

The [Policyholder's] [Participating Unit's] participation in a PPO network does not mean that an insured person's choice of provider will be restricted. The insured person may seek needed medical care from any Hospital, Physician, or other provider of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the insured persons are urged to obtain such care from Preferred Providers whenever possible.

The Principal has the right to terminate the preferred provider organization (PPO) portion of this Group Policy if The Principal or the preferred provider organization (PPO) terminates the arrangement.

The Principal also has the right to identify different preferred provider organizations from time to time, and to terminate the designation of any Preferred Provider at any time.]

## **[Preferred Provider Organization (PPO) Service Area**

The geographic area within which Preferred Provider services are available to persons insured under this Group Policy.]

## **[Prevailing Charges**

- a. For medical care received from Preferred Providers, the negotiated fee between the Preferred Provider and the PPO.
- [b. For medical care received from Non-Preferred Providers, the amount, as determined by The Principal, that most health care providers charge within a geographic cost area for a Treatment or Service.

For the purpose of coverage provided under this Group Policy, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by The Principal [75%] or more of all other charges reported to The Principal for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.]

- [b. For medical care received from Non-Preferred Providers, the amount as determined by The Principal that is derived from a cost-based methodology used by Medicare or a methodology similar to one used by Medicare.]

- c. For Home Infusion Therapy Services, the amount will be established by The Principal at the time services are preapproved, not to exceed the Average Wholesale Price.
- [d. For medical care received from a Transplant Network Provider, the amount will be based on the negotiated fee.]
- e. For drugs and medicines requiring a Physician's prescription and considered a covered Treatment or Service, Prevailing Charges will not exceed the Average Wholesale Price.]
- [f. For purposes of Treatment or Service for a Medical Emergency provided outside the United States, the Prevailing Charge will be calculated based on the [Policyholder's] [Participating Unit's] United States Address.]]

### **[Prevailing Charges**

- [a. As determined by The Principal, the amount that most health care providers charge within a geographic cost area for a Treatment or Service.

For purposes of the coverage provided under this Group Policy, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by The Principal, [80%] or more of all other charges reported to The Principal for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.]

- [a. For medical care received, the amount as determined by The Principal that is derived from a cost-based methodology used by Medicare, or a methodology similar to one used by Medicare.]
- b. For Home Infusion Therapy Services, the amount will be established by The Principal at the time services are preapproved, not to exceed the Average Wholesale Price.
- [c. For medical care received from a Transplant Network Provider, the amount will be based on the negotiated fee.]
- d. For drugs and medicines requiring a Physician's prescription and considered a covered Treatment or Service, Prevailing Charges will not exceed the Average Wholesale Price.]
- [e. For purposes of Treatment or Service for a Medical Emergency provided outside the United States, the Prevailing Charge will be calculated based on the [Policyholder's] [Participating Unit's] United States Address.]]

### **[Primary Care Physician**

A Physician who is a family or general practitioner, internist, obstetrician/gynecologist or pediatrician.]

### **[Prior Plan**

The group medical expense coverage of the [Policyholder] [or a] [Participating Unit] for which this Group Policy is a replacement.]

## **Psychiatric Hospital**

[1] An institution that is licensed as a Hospital by the proper authority of the state in which it is located,  
[2] and is primarily engaged in providing diagnostic and therapeutic [Mental Health or Behavioral  
Treatment Services]/[*Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services*].

[1] For the purpose of this definition, a Psychiatric Hospital will also include any inpatient bed in a  
[2] licensed general Hospital used to provide diagnostic and therapeutic [Mental Health or Behavioral  
Treatment Services]/[*Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services*] in the  
absence of a specialized or designated psychiatric or drug treatment unit.

## **Signed or Signature**

Any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by The Principal.

## **Skilled Nursing Facility**

An institution (including one providing sub-acute care), or distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- a. is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.); and
- b. has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and
- c. has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and
- d. provides 24-hour nursing care and other medical treatment.

[1] Not included are rest homes, homes for the aged, nursing homes, or places which furnish [Mental  
[2] Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services]/[*Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services*].

## **[Specialty Provider**

Any Physician other than a Primary Care Physician who is classified as a specialist by the American Boards of Medical Specialties; or who is designated by this Group Policy as a Specialty Provider.]

## **[Temporomandibular Services**

Any Treatment or Service to diagnose, prevent, or correct malfunction, degeneration, disease, injury, and all other ailments or defects (congenital or hereditary) related to the joints, muscles, and tissues that connect the jaw to the skull.]

**Total Disability; Totally Disabled**

- a. For a Member [(other than a retired Member)], a Member's inability, as determined by The Principal, due to sickness or injury, to work at any job that reasonably fits his or her background or training.
- [b. For a Dependent [(or a retired Member)], a substantial impairment, due to sickness or injury, that prevents the individual from performing the normal function of his or her regular duties or activities.]

**[Transplant Network**

Any network of providers that The Principal determines to be an appropriate transplant network and that has contracted to provide Transplant Services subject to a negotiated fee schedule as provided in PART IV, Section [A](5). The Transplant Network is [United Resource Networks.]

**Treatment or Service**

When used in this Group Policy, the term "Treatment or Service" will be considered to mean: "confinement, treatment, service, substance, material, or device".

**Waiting Period**

With respect to a Group Health Plan and an individual who is a potential enrollee in the plan, the period of time that must pass with respect to the individual before he or she is eligible to be covered for benefits under the terms of the plan.

[The Waiting Period for coverage of a Member [and his or her eligible Dependents] under this Group Policy is [three consecutive months] of continuous employment as a Member, as described in PART III, Section A.]

**Written or Writing**

A record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

## **PART IV - BENEFITS**

[1] **Section A (4) – /Mental Health or Behavioral Treatment Services and Alcohol or Drug**  
[2] **Abuse Treatment Services//*Mental Health, Behavioral, Alcohol or Drug Abuse***  
***Treatment Services***

[1] **[Article 1 - Payment Conditions - Mental Health or Behavioral Treatment Services and**  
**Alcohol or Drug Abuse Treatment Services**

The following benefits will be payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. These benefits will be payable instead of any other benefits described in this Group Policy, except as otherwise indicated in this Article 1. In the event the Member [or Dependent] receives Treatment or Services for more than one condition during the same period of time, benefits will be paid based on the primary focus of the Treatment or Service, as determined by The Principal.

**a. Mental Health or Behavioral Treatment Services**

**(1) Inpatient Hospital Services**

If a Member [or Dependent] is Hospital Inpatient Confined in a Psychiatric Hospital, a psychiatric unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.

Benefits will be payable as described in (5) below.

**(2) Partial Hospitalization or Day Treatment Services**

If a Member [or Dependent] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described in (5) below.

"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital, a Psychiatric Hospital, a licensed outpatient psychiatric center, a Community Mental Health Center, or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.

"Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health or Behavioral Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

## **PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),**  
**/Mental Health or Behavioral Treatment Services and**  
**Alcohol or Drug Abuse Treatment Services//*Mental Health, Behavioral, Alcohol or Drug***  
***Abuse Treatment Services***

### (3) Outpatient Services

If a Member [or Dependent] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Psychiatric Hospital, outpatient psychiatric center, or Community Mental Health Center, benefits will be payable as described in (5) below.

"Outpatient Services" mean Mental Health or Behavioral Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.

Covered Charges for Outpatient Services are limited to the following services:

- Crisis intervention or stabilization;
- Psychological testing;
- Individual psychotherapy;
- Family therapy;
- Group therapy;
- Electroconvulsive therapy;
- Psychiatric medication management;
- [- Biofeedback;]
- Behavior modification treatment;
- [- Hypnotherapy;]
- Narcosynthesis.

### (4) Physician Visits

If a Member [or Dependent] receives any Mental Health or Behavioral Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:

- **While Hospital Inpatient Confined:** Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described under (5) below.
- **While Receiving Partial Hospitalization or Day Treatment Services:** Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described under (5) below.
- **All Other Physician Visits:** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services are Outpatient Services and will be payable as described under (5) below. Covered services will be those listed under Outpatient Services in (3) above.

## PART IV - BENEFITS

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services/[Mental Health, Behavioral, Alcohol or Drug  
Abuse Treatment Services]**



**(5) Benefits Payable**

- (a) Inpatient Hospital Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible that applies to any other Inpatient Hospital Confinement, as well as the calendar year maximum benefit described in (6) below.

[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by The Principal for Inpatient Hospital Confinement will not be considered Covered Charges.]

- (b) Partial Hospitalization or Day Treatment Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the calendar year Deductible, as well as the calendar year maximum benefit described in (6) below.
- (c) Outpatient Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible that applies to any other outpatient services, as well as the calendar year maximum benefit described in (6) below.
- (d) Physician Visits:** Benefits will be payable at [80%] of Covered Charges and will be subject to any applicable calendar year Deductible, as well as the calendar year maximum benefit described in (6) below.

The [80%] coinsurance rate described in (a), (b), (c), or (d) above applies whether or not the Member [or Dependent] has satisfied the Out-of-Pocket Expense limit described in PART IV, Section A (2).

**(6) Calendar Year Maximum**

The maximum benefit payable for any combination of Covered Charges described in (1), (2), (3), or (4) above will be limited to a maximum benefit of [\$7,500] each calendar year for each insured person.

**b. Alcohol or Drug Abuse Treatment Services**

**(1) Inpatient Hospital Services**

*If a Member [or Dependent] is Hospital Inpatient confined in an Inpatient Alcohol or Drug Abuse Treatment Facility or an alcohol/drug unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.*

*Benefits will be payable as described in (5) below.*

**PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services/[Mental Health, Behavioral, Alcohol or Drug  
Abuse Treatment Services]**

**(2) Partial Hospitalization or Day Treatment Services**

*If a Member [or Dependent] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described in (5) below.*

*"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

*"Partial Hospitalization or Day Treatment Services" means a structured program under the supervision of a Physician, which provided diagnostic and therapeutic Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.*

**(3) Outpatient Services**

*If a Member [or Dependent] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, or Outpatient Alcohol or Drug Abuse Treatment Facility, benefits will be payable as described in (5) below.*

*"Outpatient Services" means Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.*

*Covered Charges for Outpatient Services are limited to the following services:*

- (a) Individual therapy;*
- (b) Family therapy;*
- (c) Group therapy;*
- (d) Alcohol or drug abuse medication management;*
- [(e) Biofeedback;]*
- (f) Behavior modification treatment;*
- (g) Alcohol or drug abuse rehabilitation or counseling services.*

**(4) Physician Visits**

*If a Member [or Dependent] receives any Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:*

- (1) While Hospital Inpatient Confined:** *Benefits will be payable for Physician Visits when provided while the person in Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described under (5) below.*

**PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services/[Mental Health, Behavioral, Alcohol or Drug  
Abuse Treatment Services]**

- (2) ***While Receiving Partial Hospitalization or Day Treatment Services:*** Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described under (5) below.
- (3) ***All Other Physician Visits:*** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services will be considered Outpatient Services and will be payable as described under (5) below. Covered services will be those listed under Outpatient Services in (3) above.

**(5) Benefits Payable**

- (a) ***Inpatient Hospital Services:*** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible or Copay that applies to any other Inpatient Hospital Confinement, as well as the Maximum Benefits described in (6) below.

*[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by The Principal for Inpatient Hospital Confinement will not be considered Covered Charges.]*

- (b) ***Partial Hospitalization or Day Treatment Services:*** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the calendar year Deductible, as well as the Maximum Benefits described in (6) below.
- (c) ***Outpatient Services:*** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible or Copay that applies to any other outpatient services, as well as the Maximum Benefits described in (6) below.
- (d) ***Physician Visits:*** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to [any applicable per-visit Copay][the calendar year Deductible], as well as the Maximum Benefits described in (6) below.

**(6) Maximum Benefits**

*For each insured person, the maximum benefit payable for any combination of Covered Charges described in (1), (2), (3), and (4) above will be limited to:*

- *[\$6,000] during any period of [two ]consecutive calendar years; and*
- *[\$12,000] during the insured person's lifetime.*

**PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services/[Mental Health, Behavioral, Alcohol or Drug  
Abuse Treatment Services]**

**c. Provisions Applicable to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services**

*For the purpose of the benefits described in this Article 1:*

- (1) No benefits will be payable for any charges incurred in excess of the limits and maximums described in this Section. The general Comprehensive Medical limitations in Section A (18) will apply to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. In addition, Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:*
  - (a) recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or*
  - (b) psychoanalysis and aversion therapy; or*
  - (c) residential mental health or behavioral Treatment or Service; or*
  - (d) after-care treatment programs for alcohol or drug abuse.*
- [(2) Benefits payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit, and this maximum will be reduced by the benefits paid; and]*
- (3) Covered Charges incurred for outpatient laboratory services and for outpatient drugs and medicines requiring a Physician's prescription are payable the same as for any other covered Treatment or Service and are not subject to the limits described in this Article 1; and*
- [(4) Charges for Outpatient Services or Partial Hospitalization or Day Treatment Services that are in excess of those approved by The Principal for Outpatient Services or for Partial Hospitalization or Day Treatment Services will not be considered Covered Charges.]*
- [(5) Benefits payable for Outpatient Services and Partial Hospitalization or Day Treatment Services will be reduced by [25%] unless the Utilization Management Requirements described in Section B1 (1A) are satisfied.]]*

**PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services/[Mental Health, Behavioral, Alcohol or Drug  
Abuse Treatment Services]**

[2] **[Article 1 – Payment Conditions – Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]**

*The following benefits will be payable for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In the event the Member [or Dependent] receives Treatment or Services for more than one condition during the same period of time, benefits will be paid based on the primary focus of the Treatment or Service, as determined by The Principal.*

**a. Inpatient Hospital Services**

*If a Member [or Dependent] is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Alcohol or Drug Abuse Treatment Facility, a psychiatric or alcohol/drug unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement. Benefits are payable the same as for any other Hospital Inpatient Confinement.*

**b. Outpatient Services**

*If a Member [or Dependent] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Psychiatric Hospital, outpatient psychiatric center, Community Mental Health Center, or Outpatient Alcohol or Drug Abuse Treatment Facility, benefits will be payable the same as for any other outpatient services.*

*"Outpatient Services" mean Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined.*

*Covered Charges for Outpatient Services are limited to the following services:*

- (1) Partial Hospitalization or Day Treatment Services;*
- (2) crisis intervention or stabilization;*
- (3) psychological testing;*
- (4) individual psychotherapy;*
- (5) family therapy;*
- (6) group therapy;*
- (7) electroconvulsive therapy;*
- (8) psychiatric alcohol or drug abuse medication management;*
- [(9) biofeedback;]*
- (10) behavior modification treatment;*
- (11) alcohol or drug abuse rehabilitation or counseling services;*
- [(12) hypnotherapy;]*
- (13) narcosynthesis.*

*For the purpose of these Outpatient Services benefits, "Partial Hospitalization or Day*

**PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services/[Mental Health, Behavioral, Alcohol or Drug  
Abuse Treatment Services]**

*Treatment Services" means a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period. "Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

**c. Physician Visits**

*If a Member [or Dependent] receives any Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable the same as for any other Physician Visit.*

**d. Benefits Payable**

*Benefits for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services are payable the same as for any other covered Treatment or Service.*

*[Benefits paid will be applied toward the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.]*

*[Charges incurred for Outpatient Services that are in excess of those approved by The Principal for Outpatient Services will not be considered Covered Charges.]*

*[Benefits payable for Outpatient Services will be reduced by [25%] unless the Utilization Management Requirements described in Section B1 (1A) of this Group Policy are satisfied.]*

*[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by The Principal for Inpatient Hospital Confinement will not be considered Covered Charges.]*

**e. Limitations**

*The general Comprehensive Medical limitations described in Section A (18) of this Group Policy will apply to Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In addition Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:*

- (1) recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or*
- (2) psychoanalysis and aversion therapy; or*
- (3) residential mental health or behavioral Treatment or Service; or*
- (4) after-care treatment programs for alcohol or drug abuse.]*

**PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services/[Mental Health, Behavioral, Alcohol or Drug  
Abuse Treatment Services]**

#### **PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services/[*Mental Health, Behavioral, Alcohol or Drug  
Abuse Treatment Services*]**

## **PART IV – BENEFITS**

[1] **Section A (4) – /Mental Health or Behavioral Treatment Services and Alcohol or Drug**  
[2] **Abuse Treatment Services//Mental Health, Behavioral, Alcohol or Drug Abuse**  
***Treatment Services***

[1] **[Article 1 - Payment Conditions - Mental Health or Behavioral Treatment Services and**  
**Alcohol or Drug Abuse Treatment Services**

The following benefits will be payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. These benefits will be payable instead of any other benefits described in this Group Policy, except as otherwise indicated in this Article 1. In the event the Member [or Dependent] receives Treatment or Services for more than one condition during the same period of time, benefits will be paid based on the primary focus of the Treatment or Service, as determined by The Principal.

### **a. Mental Health or Behavioral Treatment Services**

#### **(1) Inpatient Hospital Services**

If a Member [or Dependent] is Hospital Inpatient Confined in a Psychiatric Hospital, a psychiatric unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.

Benefits will be payable as described in (5) below.

#### **(2) Partial Hospitalization or Day Treatment Services**

If a Member [or Dependent] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described in (5) below.

"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital, a Psychiatric Hospital, a licensed outpatient psychiatric center, a Community Mental Health Center, or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.

"Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health or Behavioral Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

## **PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),**  
**/Mental Health or Behavioral Treatment Services and**  
**Alcohol or Drug Abuse Treatment Services//Mental Health,**  
***Behavioral, Alcohol or Drug Abuse Treatment Services***



### (3) Outpatient Services

If a Member [or Dependent] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Psychiatric Hospital, outpatient psychiatric center, or Community Mental Health Center, benefits will be payable as described in (5) below.

"Outpatient Services" mean Mental Health or Behavioral Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.

Covered Charges for Outpatient Services are limited to the following services:

- Crisis intervention or stabilization;
- Psychological testing;
- Individual psychotherapy;
- Family therapy;
- Group therapy;
- Electroconvulsive therapy;
- Psychiatric medication management;
- [- Biofeedback;]
- Behavior modification treatment;
- [- Hypnotherapy;]
- Narcosynthesis.

### (4) Physician Visits

If a Member [or Dependent] receives any Mental Health or Behavioral Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:

- **While Hospital Inpatient Confined:** Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described under (5) below.
- **While Receiving Partial Hospitalization or Day Treatment Services:** Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described under (5) below.
- **All Other Physician Visits:** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services are Outpatient Services and will be payable as described under (5) below. Covered services will be those listed under Outpatient Services in (3) above.

## PART IV - BENEFITS

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services//Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services/**

**(5) Benefits Payable**

- (a) Inpatient Hospital Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible or Copay that applies to any other Inpatient Hospital Confinement, as well as the calendar year maximum benefit described in (6) below.

[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by The Principal for Inpatient Hospital Confinement will not be considered Covered Charges.]

- (b) Partial Hospitalization or Day Treatment Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the calendar year Deductible, as well as the calendar year maximum benefit described in (6) below.
- (c) Outpatient Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible or Copay that applies to any other outpatient services, as well as the calendar year maximum benefit described in (6) below.
- (d) Physician Visits:** Benefits will be payable at [80%] of Covered Charges and will be subject to [any applicable per-visit Copay][the calendar year Deductible], as well as the calendar year maximum benefit described in (6) below.

The [80%] coinsurance rate described in (a), (b), (c), or (d) above applies whether or not the Member [or Dependent] has satisfied the [Out-of-Pocket Expense limit] [Coinsurance Maximums] described in PART IV, Section A (2).

**(6) Calendar Year Maximum**

The maximum benefit payable for any combination of Covered Charges described in (1), (2), (3), or (4) above will be limited to a maximum benefit of [\$7,500] each calendar year for each insured person.

***b. Alcohol or Drug Abuse Treatment Services***

***(1) Inpatient Hospital Services***

*If a Member [or Dependent] is Hospital Inpatient confined in an Inpatient Alcohol or Drug Abuse Treatment Facility or an alcohol/drug unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.*

**PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services//Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services]**

*Benefits will be payable as described in (5) below.*

**(2) Partial Hospitalization or Day Treatment Services**

*If a Member [or Dependent] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described in (5) below.*

*"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

*"Partial Hospitalization or Day Treatment Services" means a structured program under the supervision of a Physician, which provided diagnostic and therapeutic Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.*

**(3) Outpatient Services**

*If a Member [or Dependent] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, or Outpatient Alcohol or Drug Abuse Treatment Facility, benefits will be payable as described in (5) below.*

*"Outpatient Services" means Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.*

*Covered Charges for Outpatient Services are limited to the following services:*

- (a) Individual therapy;*
- (b) Family therapy;*
- (c) Group therapy;*
- (d) Alcohol or drug abuse medication management;*
- [(e) Biofeedback;]*
- (f) Behavior modification treatment;*
- (g) Alcohol or drug abuse rehabilitation or counseling services.*

**(4) Physician Visits**

*If a Member [or Dependent] receives any Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:*

- (1) While Hospital Inpatient Confined:** *Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described under (5) below.*

**PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services//Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services/**

- (2) ***While Receiving Partial Hospitalization or Day Treatment Services:*** Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described under (5) below.
- (3) ***All Other Physician Visits:*** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services will be considered Outpatient Services and will be payable as described under (5) below. Covered services will be those listed under Outpatient Services in (3) above.

**(5) Benefits Payable**

- (a) ***Inpatient Hospital Services:*** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible or Copay that applies to any other Inpatient Hospital Confinement, as well as the Maximum Benefits described in (6) below.

[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by The Principal for Inpatient Hospital Confinement will not be considered Covered Charges.]

- (b) ***Partial Hospitalization or Day Treatment Services:*** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the calendar year Deductible, as well as the Maximum Benefits described in (6) below.
- (c) ***Outpatient Services:*** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible or Copay that applies to any other outpatient services, as well as the Maximum Benefits described in (6) below.
- (d) ***Physician Visits:*** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to [any applicable per-visit Copay][the calendar year Deductible], as well as the Maximum Benefits described in (6) below.

**(6) Maximum Benefits**

For each insured person, the maximum benefit payable for any combination of Covered Charges described in (1), (2), (3), and (4) above will be limited to:

- [\$6,000] during any period of [two ]consecutive calendar years; and
- [\$12,000] during the insured person's lifetime.

**PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services//Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services]**

**c. Provisions Applicable to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services**

*For the purpose of the benefits described in this Article 1:*

- (1) No benefits will be payable for any charges incurred in excess of the limits and maximums described in this Section. The general Comprehensive Medical limitations in Section A (18) will apply to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. In addition, Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:*
  - (a) recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or*
  - (b) psychoanalysis and aversion therapy; or*
  - (c) residential mental health or behavioral Treatment or Service; or*
  - (d) after-care treatment programs for alcohol or drug abuse.*
- [(2) Benefits payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit, and this maximum will be reduced by the benefits paid; and]*
- (3) Covered Charges incurred for outpatient laboratory services and for outpatient drugs and medicines requiring a Physician's prescription are payable the same as for any other covered Treatment or Service and are not subject to the limits described in this Article 1; and*
- [(4) Charges for Outpatient Services or Partial Hospitalization or Day Treatment Services that are in excess of those approved by The Principal for Outpatient Services or for Partial Hospitalization or Day Treatment Services will not be considered Covered Charges.]*
- [(5) Benefits payable for Outpatient Services and Partial Hospitalization or Day Treatment Services will be reduced by [25%] unless the Utilization Management Requirements described in Section B1 (1A) are satisfied.]]*

**PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services]/Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services]**

[2] **[Article 1 – Payment Conditions – Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]**

*The following benefits will be payable for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In the event the Member [or Dependent] receives Treatment or Services for more than one condition during the same period of time, benefits will be paid based on the primary focus of the Treatment or Service, as determined by The Principal.*

**a. Inpatient Hospital Services**

*If a Member [or Dependent] is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Alcohol or Drug Abuse Treatment Facility, a psychiatric or alcohol/drug unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement. Benefits are payable the same as for any other Hospital Inpatient Confinement.*

**b. Outpatient Services**

*If a Member [or Dependent] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Psychiatric Hospital, outpatient psychiatric center, Community Mental Health Center, or Outpatient Alcohol or Drug Abuse Treatment Facility, benefits will be payable the same as for any other outpatient services.*

*"Outpatient Services" mean Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined.*

*Covered Charges for Outpatient Services are limited to the following services:*

- (1) Partial Hospitalization or Day Treatment Services;*
- (2) crisis intervention or stabilization;*
- (3) psychological testing;*
- (4) individual psychotherapy;*
- (5) family therapy;*
- (6) group therapy;*
- (7) electroconvulsive therapy;*
- (8) psychiatric alcohol or drug abuse medication management;*
- [(9) biofeedback;]*
- (10) behavior modification treatment;*
- (11) alcohol or drug abuse rehabilitation or counseling services;*
- [(12) hypnotherapy;]*
- (13) narcosynthesis.*

*For the purpose of these Outpatient Services benefits, "Partial Hospitalization or Day*

**PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services//Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services]**

*Treatment Services" means a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period. "Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

**c. Physician Visits**

*If a Member [or Dependent] receives any Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable the same as for any other Physician Visit.*

**d. Benefits Payable**

*Benefits for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services are payable the same as for any other covered Treatment or Service.*

*[Benefits paid will be applied toward the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.]*

*[Charges incurred for Outpatient Services that are in excess of those approved by The Principal for Outpatient Services will not be considered Covered Charges.]*

*[Benefits payable for Outpatient Services will be reduced by [25%] unless the Utilization Management Requirements described in Section B1 (1A) of this Group Policy are satisfied.]*

*[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by The Principal for Inpatient Hospital Confinement will not be considered Covered Charges.]*

**e. Limitations**

*The general Comprehensive Medical limitations described in Section A (18) of this Group Policy will apply to Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In addition Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:*

- (1) recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or*
- (2) psychoanalysis and aversion therapy; or*
- (3) residential mental health or behavioral Treatment or Service; or*
- (4) after-care treatment programs for alcohol or drug abuse.]*

## **PART IV - BENEFITS**

**Section A (4) – Comprehensive Medical Expense Insurance (PPO),  
/Mental Health or Behavioral Treatment Services and  
Alcohol or Drug Abuse Treatment Services//Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services]**

## **PART IV - BENEFITS**

- [1] **Section B (4) – /Mental Health or Behavioral Treatment Services and Alcohol or Drug**  
[2] **Abuse Treatment Services//*Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services***

- [1] **[Article 1 - Payment Conditions - Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services**

The following benefits will be payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. These benefits will be payable instead of any other benefits described in this Group Policy, except as otherwise indicated in this Article 1. In the event the Member [or Dependent] receives Treatment or Services for more than one condition during the same period of time, benefits will be paid based on the primary focus of the Treatment or Service, as determined by The Principal.

**a. Mental Health or Behavioral Treatment Services**

**(1) Inpatient Hospital Services**

If a Member [or Dependent] is Hospital Inpatient Confined in a Psychiatric Hospital, a psychiatric unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.

Benefits will be payable as described in (5) below.

**(2) Partial Hospitalization or Day Treatment Services**

If a Member [or Dependent] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described in (5) below.

"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital, a Psychiatric Hospital, a licensed outpatient psychiatric center, a Community Mental Health Center, or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.

"Partial Hospitalization or Day Treatment Services" means a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health or Behavioral Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

## **PART IV - BENEFITS**

**Section B (4) – Comprehensive Medical Expense Insurance,  
/Mental Health or Behavioral Treatment Services  
and Alcohol or Drug Abuse Treatment Services//*Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services***



### (3) Outpatient Services

If a Member [or Dependent] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Psychiatric Hospital, outpatient psychiatric center, or Community Mental Health Center, benefits will be payable as described in (5) below.

"Outpatient Services" means Mental Health or Behavioral Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services. Covered Charges for Outpatient Services are limited to the following services:

- (a) Crisis intervention or stabilization;
- (b) Psychological testing;
- (c) Individual psychotherapy;
- (d) Family therapy;
- (e) Group therapy;
- (f) Electroconvulsive therapy;
- (g) Psychiatric medication management;
- [(h) Biofeedback;]
- (i) Behavior modification treatment;
- [(j) Hypnotherapy;]
- (k) Narcosynthesis.

### (4) Physician Visits

If a Member [or Dependent] receives any Mental Health or Behavioral Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:

- (a) **While Hospital Inpatient Confined:** Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described under (5) below.
- (b) **While Receiving Partial Hospitalization or Day Treatment Services:** Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described under (5) below.
- (c) **All Other Physician Visits:** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services are Outpatient Services and will be payable as described under (5) below. Covered services will be those listed under Outpatient Services in (3) above.

## PART IV - BENEFITS

**Section B (4) – Comprehensive Medical Expense Insurance,  
/Mental Health or Behavioral Treatment Services  
and Alcohol or Drug Abuse Treatment Services/***Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services]*

**(5) Benefits Payable**

- (a) Inpatient Hospital Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible or Copay that applies to any other Inpatient Hospital Confinement, as well as the calendar year maximum benefit described in (6) below.

[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by The Principal for Inpatient Hospital Confinement will not be considered Covered Charges.]

- (b) Partial Hospitalization or Day Treatment Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the calendar year Deductible, as well as the calendar year maximum benefit described in (6) below.
- (c) Outpatient Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible or Copay that applies to any other outpatient services, as well as the calendar year maximum benefit described in (6) below.
- (d) Physician Visits:** Benefits will be payable at [80%] of Covered Charges and will be subject to [any applicable per-visit Copay][the calendar year Deductible], as well as the calendar year maximum benefit described in (6) below.

The [80%] coinsurance rate described in (a), (b), (c), or (d) above applies whether or not the Member [or Dependent] has satisfied the Out-of-Pocket Expense limit described in this PART IV, Section B (2).

**(6) Calendar Year Maximum**

The maximum benefit payable for any combination of Covered Charges described in (1), (2), (3), or (4) above will be limited to a maximum benefit of [\$7,500] each calendar year for each insured person.

***b. Alcohol or Drug Abuse Treatment Services***

***(1) Inpatient Hospital Services***

*If a Member [or Dependent] is Hospital Inpatient confined in an Inpatient Alcohol or Drug Abuse Treatment Facility or an alcohol/drug unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.*

**PART IV - BENEFITS**

**Section B (4) – Comprehensive Medial Expense Insurance,  
/Mental Health or Behavioral Treatment Services  
and Alcohol or Drug Abuse Treatment Services[/Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services]**

*Benefits will be payable as described in (5) below.*

**(2) Partial Hospitalization or Day Treatment Services**

*If a Member [or Dependent] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described in (5) below.*

*"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

*"Partial Hospitalization or Day Treatment Services" means a structured program under the supervision of a Physician, which provided diagnostic and therapeutic Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.*

**(3) Outpatient Services**

*If a Member [or Dependent] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, or Outpatient Alcohol or Drug Abuse Treatment Facility, benefits will be payable as described in (5) below.*

*"Outpatient Services" means Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.*

*Covered Charges for Outpatient Services are limited to the following services:*

- (a) Individual therapy;*
- (b) Family therapy;*
- (c) Group therapy;*
- (d) Alcohol or drug abuse medication management;*
- [(e) Biofeedback;]*
- (f) Behavior modification treatment;*
- (g) Alcohol or drug abuse rehabilitation or counseling services.*

**(4) Physician Visits**

*If a Member [or Dependent] receives any Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:*

- (1) While Hospital Inpatient Confined:** *Benefits will be payable for Physician Visits when provided while the person in Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described under (5) below.*

**PART IV - BENEFITS**

**Section B (4) – Comprehensive Medical Expense Insurance,  
/Mental Health or Behavioral Treatment Services  
and Alcohol or Drug Abuse Treatment Services/[Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services]**

- (2) **While Receiving Partial Hospitalization or Day Treatment Services:** Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described under (5) below.
- (3) **All Other Physician Visits:** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services will be considered Outpatient Services and will be payable as described under (5) below. Covered services will be those listed under Outpatient Services in (3) above.

**(5) Benefits Payable**

- (a) **Inpatient Hospital Services:** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible or Copay that applies to any other Inpatient Hospital Confinement, as well as the Maximum Benefits described in (6) below.

*[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by The Principal for Inpatient Hospital Confinement will not be considered Covered Charges.]*

- (b) **Partial Hospitalization or Day Treatment Services:** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the calendar year Deductible, as well as the Maximum Benefits described in (6) below.
- (c) **Outpatient Services:** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible or Copay that applies to any other outpatient services, as well as the Maximum Benefits described in (6) below.
- (d) **Physician Visits:** Benefits will be payable the same as for any other covered Treatment or Service and will be subject to [any applicable per-visit Copay][the calendar year Deductible], as well as the Maximum Benefits described in (6) below.

*Charges for Alcohol or Drug Abuse Treatment Services will apply toward the Out-of-Pocket limits.*

**(6) Maximum Benefits**

*For each insured person, the maximum benefit payable for any combination of Covered Charges described in (1), (2), (3), and (4) above will be limited to:*

- *[\$6,000] during any period of [two ]consecutive calendar years; and*

**PART IV - BENEFITS**

**Section B (4) – Comprehensive Medical Expense Insurance,  
/Mental Health or Behavioral Treatment Services  
and Alcohol or Drug Abuse Treatment Services/[/Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services/]**

- [\$12,000] during the insured person's lifetime.

**c. Provisions Applicable to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services**

*For the purpose of the benefits described in this Article 1:*

- (1) No benefits will be payable for any charges incurred in excess of the limits and maximums described in this Section. The general Comprehensive Medical limitations in Section B (18) will apply to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. In addition, Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:*
  - (a) recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or*
  - (b) psychoanalysis and aversion therapy; or*
  - (c) residential mental health or behavioral Treatment or Service; or*
  - (d) after-care treatment programs for alcohol or drug abuse.*
- [(2) Benefits payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit, and this maximum will be reduced by the benefits paid; and]*
- (3) Covered Charges incurred for outpatient laboratory services and for outpatient drugs and medicines requiring a Physician's prescription are payable the same as for any other covered Treatment or Service and are not subject to the limits described in this Article 1; and*
- [(4) Charges for Outpatient Services or Partial Hospitalization or Day Treatment Services that are in excess of those approved by The Principal for Outpatient Services or for Partial Hospitalization or Day Treatment Services will not be considered Covered Charges.]*
- [(5) Benefits payable for Outpatient Services and Partial Hospitalization or Day Treatment Services will be reduced by [25%] unless the Utilization Management Requirements described in Section B1 (1) are satisfied.]]*

**PART IV - BENEFITS**

**Section B (4) – Comprehensive Medical Expense Insurance,  
/Mental Health or Behavioral Treatment Services  
and Alcohol or Drug Abuse Treatment Services/[Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services]**

[2] **[Article 1 – Payment Conditions – Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]**

*The following benefits will be payable for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In the event the Member [or Dependent] receives Treatment or Services for more than one condition during the same period of time, benefits will be paid based on the primary focus of the Treatment or Service, as determined by The Principal.*

**a. Inpatient Hospital Services**

*If a Member [or Dependent] is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Alcohol or Drug Abuse Treatment Facility, a psychiatric or alcohol/drug unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement. Benefits are payable the same as for any other Hospital Inpatient Confinement.*

**b. Outpatient Services**

*If a Member [or Dependent] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Psychiatric Hospital, outpatient psychiatric center, Community Mental Health Center, or Outpatient Alcohol or Drug Abuse Treatment Facility, benefits will be payable the same as for any other outpatient services.*

*"Outpatient Services" mean Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined.*

*Covered Charges for Outpatient Services are limited to the following services:*

- (1) Partial Hospitalization or Day Treatment Services;*
- (2) crisis intervention or stabilization;*
- (3) psychological testing;*
- (4) individual psychotherapy;*
- (5) family therapy;*
- (6) group therapy;*
- (7) electroconvulsive therapy;*
- (8) psychiatric alcohol or drug abuse medication management;*
- [(9) biofeedback;]*
- (10) behavior modification treatment;*
- (11) alcohol or drug abuse rehabilitation or counseling services;*
- [(12) hypnotherapy;]*
- (13) narcosynthesis.*

*For the purpose of these Outpatient Services benefits, "Partial Hospitalization or Day*

**PART IV - BENEFITS**

**Section B (4) – Comprehensive Medical Expense Insurance,  
/Mental Health or Behavioral Treatment Services  
and Alcohol or Drug Abuse Treatment Services/[Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services]**

*Treatment Services" means a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period. "Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

**c. Physician Visits**

*If a Member [or Dependent] receives any Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable the same as for any other Physician Visit.*

**d. Benefits Payable**

*Benefits for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services are payable the same as for any other covered Treatment or Service.*

*[Benefits paid will be applied toward the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.]*

*[Charges incurred for Outpatient Services that are in excess of those approved by The Principal for Outpatient Services will not be considered Covered Charges.]*

*[Benefits payable for Outpatient Services will be reduced by [25%] unless the Utilization Management Requirements described in Section B1 (1) of this Group Policy are satisfied.]*

*[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by The Principal for Inpatient Hospital Confinement will not be considered Covered Charges.]*

**e. Limitations**

*The general Comprehensive Medical limitations described in Section B (18) of this Group Policy will apply to Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In addition Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:*

- (1) recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or*
- (2) psychoanalysis and aversion therapy; or*
- (3) residential mental health or behavioral Treatment or Service; or*
- (4) after-care treatment programs for alcohol or drug abuse.]*

## **PART IV - BENEFITS**

**Section B (4) – Comprehensive Medical Expense Insurance,  
[Mental Health or Behavioral Treatment Services  
and Alcohol or Drug Abuse Treatment Services]/[Mental Health,  
Behavioral, Alcohol or Drug Abuse Treatment Services]**

## SUMMARY OF BENEFITS (effective [JANUARY 1, 2005])

### COMPREHENSIVE MEDICAL EXPENSE INSURANCE

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

If you [or one of your Dependents] are sick or injured, Scheduled Benefits then in force will be payable for Medically Necessary Care. Scheduled Benefits are based on your class:

Class	Scheduled Benefits
All Members [and their Dependents].....	[Comprehensive Medical]

### COPAY AMOUNTS

[- For each period of Hospital Inpatient Confinement.....	The first day room and board charges (but not more than the Hospital Room Maximum for each day of confinement in a private room). [This Copay is in addition to the calendar year Deductible shown below.]
[- For each period of Hospital Inpatient Confinement.....	[\$200] for each admission. [This Copay is in addition to the calendar year Deductible shown below.]
[- For each emergency room visit (Copay waived if admitted).....	[\$100] [This Copay is in addition to the calendar year Deductible shown below.] ]
[- For Physician Visit Charges .....	[\$25] for each visit]

Copay amounts will continue to apply after the calendar year Deductible and the Out-of-Pocket Expense limits have been satisfied. In addition, Copay amounts cannot be used to satisfy the family Deductible limit described below.

In addition, the Copay provision does not apply to charges incurred for MRIs, CATs, PETs, SPECTs and other similar imaging tests. These charges are subject to the calendar year Deductible.



## DEDUCTIBLE AMOUNTS

**Individual**..... \$[500] per calendar year

**[Family]** ..... \$[1500] per calendar year

The family maximum Deductible for all persons in the same family (you and your Dependents) each calendar year will be \$[1500] (but not counting more than \$ [500] for any one person in your family). When the family maximum Deductible is satisfied for a calendar year, benefits will be payable as if the individual Deductibles had been satisfied for each person in your family.]

There is no Deductible or Copay required for [Lab Card] Outpatient Laboratory Services.

## OUT-OF-POCKET EXPENSE LIMITS

- **Per person/per calendar year**..... [\$ 5,000]

- **Per family/per calendar year** ..... [\$ 6,000]

The following charges will not count toward satisfaction of the Out-of-Pocket Expense limits:

- [- Covered Charges for which no benefits are payable because of the Utilization Management Requirements penalty; or]
- [- The Hospital per admission Copay amount; or]
- [- The Physician Visit Charges per-visit Copay amount; or]
- [- The emergency room per-visit Copay amount/[./]/; or]
- [- Covered Charges for Mental Health or Behavioral Treatment Services.]

[For Physician Visit Charges, the coinsurance amount that you [and your Dependent] must pay after the Copay amount will be counted toward satisfaction of the Out-of-Pocket Expense limits, but will not be counted toward satisfaction of the calendar year Deductible Amount.]

## Physician Visit Charges

Covered Charges will include charges for Physician Visits. Benefits will be payable at [100%] of Physician Visit Charges (other than charges incurred for outpatient, clinic or office-based surgery, magnetic resonance imaging (MRIs); computerized axial tomography (CATs); positron emission tomography (PETs) and single photon emission computerized tomography (SPECTs) or other similar imaging tests) in excess of the applicable Copay amount up to[ \$500 per visit.] Additional benefits beyond the [\$500 per visit] limit will be subject to the Calendar Year Deductible and Coinsurance percentage. Benefits for charges incurred for outpatient, clinic or office-based surgery; magnetic resonance imaging (MRIs); computerized axial tomography (CATs); positron emission tomography (PETs); single photon emission computerized tomography (SPECTs) or other similar imaging tests will be paid subject to the Calendar Year Deductible and Coinsurance.

## BENEFITS PAYABLE

Benefits payable for Treatment or Service received each calendar year will be:

- [80%] of each person's Covered Charges in excess of the applicable Deductible or Copay amount described above until the Out-of-Pocket Expense maximum is reached; and
- 100% of all remaining Covered Charges in excess of the Out-of-Pocket Expense maximum.

The following exceptions apply to the Benefits Payable provisions described above:

- For [Hospital Inpatient Confinement Charges] and [all charges incurred for services listed in this booklet under Pretreatment Review], benefits payable will be [reduced by [25%] (but not more than [\$2,000] per individual each calendar year)] unless the Utilization Management Requirements are satisfied. **See page GH 407 CC for a complete description of the Utilization Management Program.**
- For *payment conditions applicable to [Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services]/[Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]*. **See page GH 412 B.**
- For payment conditions applicable to Transplant Services, see page GH 412 C.
- For payment conditions applicable to emergency room treatment, see GH 412 H.
- [- For payment conditions applicable to Rehabilitative Services, see GH 412 F]
- [- For payment conditions applicable to Wellness Services, see GH 412 E]
- [- For payment conditions applicable to outpatient Laboratory Services, see GH 412 G.]

## BENEFIT MAXIMUMS

[Overall Lifetime] Maximum Payment Limit..... [\$2,000,000][Unlimited]

As described below, there are other Lifetime Maximum Payment Limits applicable to certain medical Treatment or Service. Benefits paid toward all such limits will be counted towards the Overall Lifetime Maximum Payment Limit shown above, and will reduce this maximum accordingly.

[1] [Alcohol or Drug Abuse Treatment Services. . . . .See GH 412 B]

Transplant Services Outside the  
Transplant Network ..... [\$500,000 during an insured person's lifetime]

Ambulance Services..... [\$5,000] per person/per calendar year

Home Health Care..... [40 visits] per person/per calendar year

Prosthetics ..... [\$25,000] during an insured person's lifetime

Skilled Nursing Facility Confinement ..... [\$800 per day/60 days] for all confinements resulting from the same sickness or injury

Durable Medical Equipment ..... [\$2,500] per person/per calendar year

### **Your Responsibilities**

- Your medical ID card includes a toll-free telephone number to call for Hospital Admission Review [and Pretreatment Review] approval(s). You must follow all of the requirements described on page GH 407 CC -- Utilization Management Program or your benefits will be reduced.

**See page GH 146 A for important claim procedure information on filing your medical claims.**

- **Prior approval** is also required for certain other services, including, but not limited to:
  - Home Health Care Services
  - Home Infusion Therapy Services
  - Skilled Nursing Facility Confinement

**Refer to the Description of Benefits section for specific details on the preapproval requirements for these services.**

### **[PRESCRIPTION DRUGS]**

#### **Benefits Payable**

For each prescription and each refill..... [100%] of Covered Charges in excess of the Copay Amount.

This variable used if plan includes Maintenance Drugs and Medicines under the Retail Drug Benefit.

#### **[Copay Amount For Maintenance Drugs and Medicines:**

An amount equal to [3-times] the applicable Copay amount shown below for "all other drugs".]

#### **Copay Amount [for All other Drugs]**

This variable used if plan has flat Copay amount:

[For each prescription and each refill ..... [\$5]]

This variable used if plan has dual Copay (i.e., Generic vs Brand Name):

[For each prescription and each refill:

- For Tier 1 Prescription Drugs: ..... [\$5]
- For Tier 2 Prescription Drugs: ..... [\$10] plus [10%] of the amount of remaining Covered Charges.]]
- [- For Tier 3 Prescription Drugs: ..... [\$15] plus [15%] of the amount of remaining Covered Charges.]]
- [- For Tier 4 Prescription Drugs: ..... [\$20] plus [20%] of the amount of remaining Covered Charges.]]
- [- For Tier 5 Prescription Drugs: ..... [\$25] plus [25%] of the amount of remaining Covered Charges.]]
- [- For Tier 6 Prescription Drugs: ..... [\$30] plus [35%] of the amount of remaining Covered Charges.]]

### **[Prescription Drugs Deductible and Copay Amount**

The individual Deductible and Copay amount for you and each of your Dependents is:

- The first [\$100] of Prescription Drugs Covered Charges incurred each calendar year; followed by
  - [- A Copay of [\$20] for each prescription and each refill.]
  - [- For each prescription and each refill, a Copay of:
    - [\$10] for Tier 1 Prescription Drugs, and
    - [\$20] for Tier2 Prescription Drugs]; and
    - [- [\$25] for Tier3 Prescription Drugs]; and]
    - [- [\$30] for Tier 4 Prescription Drugs]; and]
    - [- [\$35] for Tier 5 Prescription Drugs; and]
    - [- [\$40 [for Tier 6 Prescription Drugs.]

[For each prescription and each refill, a Copay of:

- For Tier 1 Prescription Drugs ..... [\$7]
- For Tier 2  
Prescription Drugs..... [\$10] plus [15%] of the remaining Covered Charges]
- For Tier 3  
Prescription Drugs  
and all other drugs..... [\$15] plus [30%] of the remaining Covered Charges]]
- [- For Tier 4  
Prescription Drugs

- and all other drugs..... [\$20] plus [30%] of the remaining Covered Charges]]
- [- For Tier 5  
Prescription Drugs  
and all other drugs..... [\$25] plus [30%] of the remaining Covered Charges]]
- [- For Tier 6  
Prescription Drugs  
and all other drugs..... [\$30] plus [30%] of the remaining Covered Charges]]

Charges incurred under the Comprehensive Medical benefits cannot be used to satisfy the Prescription Drugs Deductible amount and vice versa.

In addition, charges incurred under this section for Prescription Drugs cannot be used to satisfy the Comprehensive Medical Out-of-Pocket Expense limits.]

If a prescription or refill is not in a select class with a Reference Drug Price:

[Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a Generic equivalent available. When a Brand name drug is dispensed but a generic equivalent was available (including situations where the Physician has specified that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription), the Member [or Dependent] must pay the difference between the Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the Brand Name Drug will apply.]

[Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. Whenever a Brand Name Drug is dispensed but a generic equivalent was available, the Member [or Dependent] must pay the difference between the Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. However, if the physician specifies that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription, benefits will be payable based on the Brand Name Drug pricing after payment of the applicable tier Copay for the Brand Name Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the.] Brand Name Drug will apply.

[If a prescription or refill is in a select class with a Reference Drug Price:

[When a drug is dispensed and the drug price is more than the Reference Drug Price (including situations where the Physician has specified that the medication must be "Dispensed as Written" on the prescription), the Member [or Dependent] must pay the difference between the Reference Drug Price and the price of the drug dispensed in addition to the applicable tier Copay. If the Reference Drug is dispensed, the Member [or Dependent] will pay the applicable tier Copay depending on the drug tier classification.]

[When a drug is dispensed and the drug price is more than the Reference Drug Price and the Physician has specified that the medication must be "Dispensed as Written" on the prescription), the Member [or Dependent] must pay the applicable tier Copay for the drug dispensed. If the Member requests that a drug be dispensed that is more costly than the Reference Drug Price, the Member [or Dependent] must pay the difference between the Reference Drug Price and the price of the drug dispensed in addition to the applicable tier Copay of the drug dispensed. If the Reference Drug is dispensed, the Member [or Dependent] will pay the applicable tier Copay depending on the drug tier classification.]

**[You will receive a list from Us showing those drugs that are included on the Preferred Brand Name Drugs list. When you receive a prescription from your Physician, you should encourage the Physician to prescribe one of the drugs from the list. Explain that your drug cost is significantly lower when you use a Preferred Brand Name Drug. Your employer also has a copy of this list.]**

**See page GH 432 for a complete description of Prescription Drugs Expense Insurance.]**

## **[MAIL SERVICE PRESCRIPTION DRUGS**

### **Benefits Payable**

For each prescription and each refill..... [100%] of charges in excess of the Copay Amount

### **[Copay Amount**

This variable used if plan has flat Copay amount:

[For each prescription and each refill ..... [\$10]]

This variable used if plan has dual Copay (i.e. Generic vs. Brand Name):

[For each prescription and each refill:

[- For Tier 1 Prescription Drugs ..... [\$10]

[- For Tier 2  
Prescription Drugs ..... [\$20] [plus [10%] of the remaining amount charged]]

[- For Tier 3  
Prescription Drugs ..... [\$25] [plus [20%] of the remaining amount charged]]

[- For Tier 4  
Prescription Drugs ..... [\$30] [plus [25%] of the remaining amount charged]]

- [- For Tier 5  
Prescription Drugs ..... [\$35] [plus [30%] of the remaining amount charged]]
- [- For Tier 6  
Prescription Drugs ..... [\$40] [plus [35%] of the remaining amount charged]]

### **[Prescription Drugs Deductible and Copay Amount**

The individual Deductible and Copay amount for you and each of your Dependents is:

-The first [\$100] of Prescription Drugs Covered Charges incurred each calendar year; followed by

[-A Copay of [\$20] for each prescription and each refill.]

[-For each prescription and each refill, a Copay of:

- [\$10] for Tier 1 Prescription Drugs, and
- [\$20] for Tier 2 Prescription Drugs]; and]
- [\$25] for Tier 3 Prescription Drugs]; and]
- [\$30] for Tier 4 Prescription Drugs]; and]
- [\$35] for Tier 6 Prescription Drugs]

[For each prescription and each refill, a Copay of:

- For Tier 1 Prescription Drugs ..... [\$7]
- For Tier 2  
Prescription Drugs..... [\$10] plus [15%] of the remaining amount charged]
- For Tier 3  
Prescription Drugs  
and all other drugs..... [\$15] plus [30%] of the remaining amount charged]
- [- For Tier 4  
Prescription Drugs  
and all other drugs..... [\$20] plus [35%] of the remaining amount charged]]
- [- For Tier 5  
Prescription Drugs  
and all other drugs..... [\$25] plus [40%] of the remaining amount charged]]

- [- For Tier 6  
Prescription Drugs  
and all other drugs..... [\$30] plus [45%] of the remaining amount  
charged]]

Charges incurred under the Comprehensive Medical benefits cannot be used to satisfy the Prescription Drugs Deductible amount and vice versa.

In addition, charges incurred under this section for Prescription Drugs cannot be used to satisfy the Comprehensive Medical Out-of-Pocket Expense limits.]

If a prescription or refill is not in a select class with a Reference Drug Price:

[Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a Generic equivalent available. When a Brand name drug is dispensed but a generic equivalent was available (including situations where the Physician has specified that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription), the Member [or Dependent] must pay the difference between the Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the Brand Name Drug will apply.]

[Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. Whenever a Brand Name Drug is dispensed but a generic equivalent was available, the Member [or Dependent] must pay the difference between the Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. However, if the physician specifies that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription, benefits will be payable based on the Brand Name Drug pricing after payment of the applicable tier Copay for the Brand Name Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the.] Brand Name Drug will apply.

[If a prescription or refill is in a select class with a Reference Drug Price:

[When a drug is dispensed and the drug price is more than the Reference Drug Price (including situations where the Physician has specified that the medication must be "Dispensed as Written" on the prescription), the Member [or Dependent] must pay the difference between the Reference Drug Price and the price of the drug dispensed in addition to the applicable tier Copay. If the Reference Drug is dispensed, the Member [or Dependent] will pay the applicable tier Copay depending on the drug tier classification.]



[When a drug is dispensed and the drug price is more than the Reference Drug Price and the Physician has specified that the medication must be "Dispensed as Written" on the prescription), the Member [or Dependent] must pay the applicable tier Copay for the drug dispensed. If the Member requests that a drug be dispensed that is more costly than the Reference Drug Price, the Member [or Dependent] must pay the difference between the Reference Drug Price and the price of the drug dispensed in addition to the applicable tier Copay of the drug dispensed. If the Reference Drug is dispensed, the Member [or Dependent] will pay the applicable tier Copay depending on the drug tier classification.]

**[You will receive a list from Us showing those drugs that are included on the Preferred Brand Name Drugs list. When you receive a prescription from your Physician, you should encourage the Physician to prescribe one of the drugs from the list. Explain that your drug cost is significantly lower when you use a Preferred Brand Name Drug. Your employer also has a copy of this list.]**

**See page GH 433 for a complete description of Mail Service Prescription Drugs Expense Insurance.]**

**SUMMARY OF BENEFITS**  
**(effective [January 1, 2005])**

**COMPREHENSIVE MEDICAL EXPENSE INSURANCE**

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

If you [or one of your Dependents][are] sick or injured, Scheduled Benefits then in force will be payable for Medically Necessary Care. Scheduled Benefits are based on your class:

<b>Class</b>	<b>Scheduled Benefit</b>
All Members [and their Dependents].....	[Comprehensive Medical]

**PREFERRED PROVIDER ORGANIZATION (PPO)**

Your employer participates in a Preferred Provider Organization (PPO) network established and administered by [John Doe PPO].

As you may know, Preferred Provider Organization networks are arrangements whereby Hospitals, Physicians, and other providers are contracted to furnish, at negotiated costs, medical care for the employees and their Dependents of participating employers.

It is expected that your employer's participation in the PPO will result in significant savings of funds needed to maintain your coverage. These savings are to be passed on to you in the form of higher benefits payable for services received by you [or a Dependent] from Preferred Providers.

Please note that your employer's participation in the PPO network does not mean that your choice of provider will be restricted. You may still seek needed medical care from any Hospital, Physician, or other provider you wish. However, in order to avoid higher charges and reduced benefit payments, you are urged to obtain such care from Preferred Providers whenever possible.

We have the right to terminate the PPO portion of this coverage if We or the PPO terminate the arrangement.

We also have the right to identify different Preferred Provider Organizations from time to time, and to terminate the designation of any Preferred Provider at any time.

A current listing of the participating Hospitals, Physicians, and other providers is available through an on-line Preferred Provider directory. By accessing the Principal Life Insurance Company website [www.principal.com](http://www.principal.com), you can review Preferred Provider directories for your PPO Network. Click on "Provider Directory," then "Search for a Medical Provider," then you can continue to follow the prompts to find your PPO Network. If you do not have internet access, you can request a paper copy of the provider directory for your PPO network from (800) 554-3392 for medical providers. Whether using the internet or a paper directory, we recommend that you (1) verify your provider's participation in the network before seeking treatment and (2) confirm PPO participation with your provider when making your appointment.

## MEDICAL CARE COVERED CHARGES

Benefits payable will be based on four Categories of medical care services as described below.

See page GH 411 A (HDHP) for a full description of Covered Charges.

### BENEFITS PAYABLE

Benefits will be payable during a calendar year as shown below, and will vary depending upon whether or not needed care is received from a Hospital, Physician, or other provider who has contracted with the Preferred Provider Organization.

<u>Service</u>	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
----------------	----------------------	--------------------------

<u>Hospital Services</u>		
--------------------------	--	--

- Inpatient Hospital Services		
-------------------------------	--	--

- Coinsurance .....	[80%]	[60%]
- Deductible .....	[\$1,000*]	[\$1,500]

Hospital Services include Covered Charges for Birthing Center Services, Ambulatory Surgery Center Services, and freestanding dialysis center services will be subject to the applicable calendar year Deductible Amount.

- Outpatient Hospital Services [(other than outpatient, clinic or office-based surgery)]		
--	--	--

- Coinsurance .....	[80%]	[60%]
- Deductible .....	[\$1,000*]	[\$1,500*]

[Outpatient, clinic or office-based surgery at a Hospital

- Coinsurance .....	[80%]	[60%]
- Deductible .....	[\$1,000*]	[\$1,500*]

<u>Service</u>	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
----------------	----------------------	--------------------------

- |                          |            |             |
|--------------------------|------------|-------------|
| - [Emergency Room Visits |            |             |
| -     Coinsurance .....  | [80%]      | [60%]       |
| -     Deductible .....   | [\$1,000*] | [\$1,500*]] |
| -                        |            |             |

Physician Hospital Services

- |  |            |            |
|--|------------|------------|
| - Physician Hospital Services<br>(including surgery and<br>Physician Visits) |            |            |
| -     Coinsurance .....  | [80%]      | [60%]      |
| -     Deductible .....   | [\$1,000*] | [\$1,500*] |
| -  |            |            |

Physician Office or Clinic Services

- |   |           |            |
|---|-----------|------------|
| - Services at a Physician's office or clinic<br>(other than for Adult Wellness, Well Child Visits<br>[and Preventive Colonoscopies ]) |           |            |
| -     Coinsurance .....   | [80%]     | [60%]      |
| --    Deductible .....  | [\$1,000] | [\$1,500*] |

For Adult Routine Physical Exam [and Preventive Colonoscopies]

- |                         |                                  |        |
|-------------------------|----------------------------------|--------|
| -     Coinsurance ..... | [100%<br>up to \$500 per visit.] | [None] |
| -     Deductible .....  | [\$25]                           | [None] |

For Well Child Visits

- |                         |        |           |
|-------------------------|--------|-----------|
| -     Coinsurance ..... | [100%] | [75%]     |
| Deductible .....        | [\$25] | [\$1,500] |

- |  |            |             |
|--|------------|-------------|
| - [Outpatient, clinic or office-based surgery at a Physician's office<br>or an Ambulatory Surgery Center |            |             |
| -     Coinsurance .....  | [80%]      | [60%]       |
| -     Deductible .....   | [\$1,000*] | [\$1,500*]] |

## All Other Covered Services

- Ambulance Services
  - Coinsurance ..... [80%] [80%]
  - Deductible ..... [\$1,000\*] [\$1,500\*]
- Other Medical Services (including MRIs, CATs, SPECTs, PETs and other similar imaging tests)
  - Coinsurance ..... [80%] [60%]
  - Deductible ..... [\$1,000\*] [\$1,500\*]

### **[Services provided by a Non-PPO anesthesiologist, radiologist, and pathologist**

For services provided by a Non-PPO anesthesiologist, radiologist, and pathologist, benefits will be payable at the PPO coinsurance level when such services are provided at a PPO Hospital (inpatient, outpatient, and emergency room) or a licensed freestanding surgical center.]

## **[DEDUCTIBLE AMOUNTS**

### **[\*- If medical care is received from Preferred Providers and you are enrolled for Member Only coverage, your Deductible Amount will be:**

-[for [Adult Wellness] [Well Child Visits], [Preventive Colonoscopies][ \$25] per person per visit. This per visit Deductible will not apply towards the calendar year Deductible but will apply to the Out-of-Pocket Expense Limit; and

-for all other covered charges, [\$1,000] each calendar year.]

### **[ If medical care is received from Preferred Providers and you are enrolled for Member and Dependent (family) coverage your Deductible Amount will be:**

-for [Adult Wellness],[ Well Child Visits],[ Preventive Colonoscopies]: [\$25] per person per visit. This per visit Deductible will not apply towards the calendar year Deductible, but it will apply to the Out-of-Pocket Expense Limit; and

- [- -for all other covered charges, [\$2,000] each calendar year for all members in the same family. The family Deductible may be satisfied by any one family member or by two or more family members. [ No benefits will be payable until the entire family Deductible of [\$2,000] has been satisfied]. After satisfaction of the Deductible, We will pay benefits as described in this booklet.]

### **[- If medical care is received from Non-Preferred Providers and you are enrolled for Member Only coverage, your Deductible will be [\$1,000] each calendar year. ]**

- **If medical care is received from Non-Preferred Providers and you are enrolled for Member and Dependent (family) coverage** your Deductible will be [\$2,000] each calendar year for each insured person. The family Deductible may be satisfied by any one family member or by two or more family members. [ No benefits will be payable until the entire family deductible of [\$2,000] has been satisfied]. After satisfaction of the Deductible, We will pay benefits as described in this booklet.]

[Covered Charges used to satisfy the individual and family maximum calendar year Deductibles that apply when care is received from PPO Providers will [not] be used to satisfy the individual and family maximums that apply when care is received from Non-PPO Providers and vice versa.]]

## **[DEDUCTIBLE AMOUNTS**

- \*- **If medical care is received from PPO Providers:** [You pay a single [\$3,000] per individual Deductible each calendar year (or [\$6,000] per family, but not counting more than [\$3,000] for any one person). After you satisfy the Deductible, We will pay Covered Charges at the rate of payment shown above.]
- \*[- **If medical care is received from Non-PPO Providers:** You pay a single [\$4,500] per individual Deductible each calendar year (or [\$9,000] per family, but not counting more than [\$4,500] for any one person). After you satisfy the Deductible, We will pay Covered Charges at the rate of payment shown above.]
- \*- You pay a [single] [\$1,500] per individual Deductible each calendar year [(or[ \$4,500] per family, but not counting more than [\$1,500] for any one person)]. After you satisfy the Deductible, We will pay Covered Charges at the rate of payment shown above.]

[Covered Charges used to satisfy the individual and family maximum calendar year Deductibles that apply when care is received from PPO Providers will [not] be used to satisfy the individual and family maximums that apply when care is received from Non-PPO Providers and vice versa.]]

## **[OUT-OF-POCKET EXPENSE MAXIMUMS (for each calendar year):**

	<b><u>PPO Providers</u></b>	<b><u>Non-PPO Providers</u></b>
<b>Per Person</b> .....	[\$3,000]	[\$4,500]
<b>(applies if you are enrolled for Member only coverage)</b>		
<b>Per Family</b> .....	[\$6,000]	[\$9,000]
<b>(applies if you are enrolled for family coverage)</b>		
[- Covered Charges used to satisfy the Out-of-Pocket Expense limits that apply when care is received from a PPO provider will [not] be used to satisfy the Out-of-Pocket Expense limits that apply when care is received from a Non-PPO Provider and vice versa.]		
- If the amount you pay for Covered Charges in any one calendar year reaches the Out-of-Pocket Expense Maximum shown above, We will pay 100% of additional Covered Charges [(except as described above under "Deductible Amounts")].		

The Covered Charges for which no benefits are payable because of the Utilization Management penalty will not count toward satisfaction of the Out-of-Pocket Expense Maximum:

[The per visit Deductible for [Adult Wellness] [Well Child Visits] [Preventive Colonoscopies] will continue to apply after the calendar year Deductible has been satisfied.]

**The following exceptions apply to the Benefits Payable provisions described above:**

- [- For medical care received from Non-PPO Providers: [Hospital Inpatient Confinement Charges] and [all charges incurred for services listed in this booklet under Pretreatment Review], benefits payable will be [reduced by [25%] (but not more than [\$2,000] per individual each calendar year)] unless the Utilization Management Requirements are satisfied.] **See page GH 407 CC for a complete description of the Utilization Management Program.**
- [- [For payment conditions applicable to [Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services]/[Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services], **see page GH 411 B (HDHP).**]
- [- For payment conditions applicable to Transplant Services, see page GH 411 C (HDHP).]
- [- For payment conditions applicable to emergency room treatment, see page GH 411 H (HDHP).]
- [- For payment conditions applicable to Rehabilitative Services, see page GH 411 F (HDHP).]
- [- For payment conditions applicable to outpatient x-ray services, see page GH 411 G (HDHP).]
- [- For payment conditions applicable to Wellness Services, see page GH 411 E (HDHP).]
- [- For payment conditions applicable to outpatient Laboratory Services, see page GH 411 G (HDHP).]
- [- For payment conditions applicable to Medical Emergency, see Special Payment Conditions described below.]

**If you [or one of your Dependents] are referred to another provider, you [or your Dependent] should verify with the Physician that the referral is for a PPO Provider. Examples of this would be an [anesthesiologist], x-ray facilities, surgeons, [radiologists], etc. If that provider is not a PPO Provider, the level of benefits for Non-PPO Providers will apply.**

**BENEFIT MAXIMUMS**

[Overall Lifetime] Maximum Payment Limit..... [\$2,000,000][Unlimited]

As described below, there are other Lifetime Maximum Payment Limits applicable to certain medical Treatments or Service. Benefits paid toward all such limits will be counted towards the

Overall Lifetime Maximum Payment Limit shown above, and will reduce this maximum accordingly.

[Alcohol or Drug Abuse Treatment or Service See GH 411 B (HDHP).]

Transplant Services Outside the Transplant Network .....	[\$500,000 during an insured person's lifetime]
Ambulance Services.....	[\$5,000] per person/per calendar year
Home Health Care.....	[40 visits] per person/per calendar year
Prosthetics .....	[\$25,000] during an insured person's lifetime
Hospice .....	[\$25,000] during an insured person's lifetime
Skilled Nursing Facility Confinement .....	[\$800 per day/60 days] for all confinements resulting from the same sickness or injury
Durable Medical Equipment .....	[\$2,500] per person/per calendar year

### **Your Responsibilities**

- **If you use providers outside the PPO network**, your medical ID card includes a toll-free telephone number to call for Hospital Admission Review [Pretreatment Review] approvals. You must follow all of the requirements described on page GH 407 CC -- Utilization Management Program or your benefits will be reduced.
- **If you use providers within the PPO network**, your PPO Physician automatically handles the Hospital Admission Review approvals.

**See page GH 146 A for important claim procedures information on filing your medical claims.**

- **Prior approval** is also required for certain other services, including, but not limited to:
  - Home Health Care Services
  - Home Infusion Therapy Services
  - Skilled Nursing Facility Confinement

**Refer to the Description of Benefits section for specific details on the preapproval requirements for these services.**



**SUMMARY OF BENEFITS**  
**(effective [January 1, 2005])**

**COMPREHENSIVE MEDICAL EXPENSE INSURANCE**

This section highlights the benefits provided under this insurance. The purpose is to give you quick access to the information you will most often want to review. **Please read the other sections of this booklet for a more detailed explanation of benefits and any limitations or restrictions that might apply.**

If you [or one of your Dependents][are] sick or injured, Scheduled Benefits then in force will be payable for Medically Necessary Care. Scheduled Benefits are based on your class:

<b>Class</b>	<b>Scheduled Benefit</b>
All Members [and their Dependents].....	[Comprehensive Medical]

**PREFERRED PROVIDER ORGANIZATION (PPO)**

Your employer participates in a Preferred Provider Organization (PPO) network established and administered by [John Doe PPO].

As you may know, Preferred Provider Organization networks are arrangements whereby Hospitals, Physicians, and other providers are contracted to furnish, at negotiated costs, medical care for the employees and their Dependents of participating employers.

It is expected that your employer's participation in the PPO will result in significant savings of funds needed to maintain your coverage. These savings are to be passed on to you in the form of higher benefits payable for services received by you [or a Dependent] from Preferred Providers.

Please note that your employer's participation in the PPO network does not mean that your choice of provider will be restricted. You may still seek needed medical care from any Hospital, Physician, or other provider you wish. However, in order to avoid higher charges and reduced benefit payments, you are urged to obtain such care from Preferred Providers whenever possible.

We have the right to terminate the PPO portion of this coverage if We or the PPO terminate the arrangement.

We also have the right to identify different Preferred Provider Organizations from time to time, and to terminate the designation of any Preferred Provider at any time.

A current listing of the participating Hospitals, Physicians, and other providers is available through an on-line Preferred Provider directory. By accessing the Principal Life Insurance Company website [www.principal.com](http://www.principal.com), you can review Preferred Provider directories for your PPO Network. Click on "Provider Directory," then "Search for a Medical Provider," then you can continue to follow the prompts to find your PPO Network. If you do not have internet access, you can request a paper copy of the provider directory for your PPO network from (800) 554-3392 for medical providers. Whether using the internet or a paper directory, we recommend that you (1) verify your provider's participation in the network before seeking treatment and (2) confirm PPO participation with your provider when making your appointment.

## MEDICAL CARE COVERED CHARGES

Benefits payable will be based on four Categories of medical care services as described below.

See page GH 411 A for a full description of Covered Charges.

### BENEFITS PAYABLE

Benefits will be payable during a calendar year as shown below, and will vary depending upon whether or not needed care is received from a Hospital, Physician, or other provider who has contracted with the Preferred Provider Organization.

<u>Service</u>	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
<u>Hospital Services</u>		
- Inpatient Hospital Services		
- Coinsurance .....	[80%]	[60%]
- Deductible .....	[\$500*]	[None]
- [Copay] .....	[None]	[[ \$1000] [per admission], in addition to the calendar year De-ductible shown above. ]

Hospital Services Covered Charges for Birthing Center Services, Ambulatory Surgery Center Services, and freestanding dialysis center services will be subject to the applicable calendar year Deductible Amount.

- |  |          |           |
|--|----------|-----------|
| - Outpatient Hospital Services [(other than outpatient, clinic or office-based surgery)] |          |           |
| - Coinsurance .....  | [80%]    | [60%]     |
| - Deductible .....   | [\$500*] | [\$1500*] |
| - [Copay] .....  | [None]   | [None]    |
| - [Outpatient, clinic or office-based Surgery at a Hospital                              |          |           |
| - Coinsurance .....  | [80%]    | [60%]     |
| - Deductible .....   | [\$500*] | [\$1500*] |
| - [Copay] .....  | [None]   | [None]]   |

<u>Service</u>	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
- [Emergency Room Visits		
- Coinsurance .....	[80%]	[60%]
- Deductible .....	[\$500*]	[\$1500*]
- [Copay] .....	[None]	[\$100 per-visit][in addition to the calendar year Deductible.] Waived if Admitted.)]

#### Physician Hospital Services

- Physician Hospital Services (including surgery and Physician Visits)
  - Coinsurance ..... [80%] [60%]
  - Deductible ..... [\$500\*] [\$1500\*]
  - [Copay] ..... [None] [None]

#### Physician Office or Clinic Services

- Services at a [Primary Care] Physician's office or clinic [(other than [outpatient, clinic or office-based surgery][and] MRIs, CATs, SPECTs, PETs and other similar imaging tests)]

["Primary Care Physician" means a Physician who is a family or general practitioner, internist, obstetrician/gynecologist or pediatrician.]

- Coinsurance ..... [100% up to \$500 per visit] [75%]
- [Copay] ..... [\$25 per-visit] [None]
- Deductible ..... [None] [\$1500\*]
- Services at a [Specialty Provider's] office or clinic [(other than [outpatient, clinic or office-based surgery][and] MRIs, CATs, SPECTs, PETs and other similar imaging tests)]

["Specialty Provider" means any Physician other than a Primary Care Physician who is classed as a specialist by the American Boards of Medical Specialties; or who is designated by the Group Policy as a Specialty Provider.]

- Coinsurance ..... [100% up to \$500 per visit] [75%]
- [Copay] ..... [\$40 per-visit] [None]
- Deductible ..... [None] [\$1500\*]

- [Outpatient, clinic or office-based surgery at a Physician's office or an Ambulatory Surgery Center
  - Coinsurance ..... [80%] [60%]
  - [Copay] ..... [None] [None]
  - Deductible ..... [\$500\*] [\$1500\*]

#### All Other Covered Services

- Ambulance Services
  - Coinsurance ..... [80%] [80%]
  - [Copay] ..... [None] [None]
  - Deductible ..... [\$500\*] [\$500\*]
- Other Medical Services (including MRIs, CATs, SPECTs, PETs and other similar imaging tests)
  - Coinsurance ..... [80%] [60%]
  - [Copay] ..... [None] [None]
  - Deductible ..... [\$500\*] [\$1500\*]

#### **[Services provided by a Non-PPO anesthesiologist, radiologist, and pathologist**

For services provided by a Non-PPO anesthesiologist, radiologist, and pathologist, benefits will be payable at the PPO coinsurance level when such services are provided at a PPO Hospital (inpatient, outpatient, and emergency room) or a licensed freestanding surgical center.]

#### **COPAY AMOUNTS**

Copays cannot be used to satisfy the individual or family calendar year Deductible maximums and will continue to apply after the calendar year Deductible and the [Out-of-Pocket Expense limits] [Coinsurance Maximum] have been satisfied. This applies to:

- [- The Hospital Services Hospital per admission Copay amount; and]
- [- The Physician Office or Clinic Services per-visit Copay amount; and]
- [- The emergency room per-visit Copay amount.]

In addition, the Copay provision does not apply to charges incurred for MRIs, CATs, SPECTs, PETs and other similar imaging tests. These charges are subject to the calendar year Deductible.

## DEDUCTIBLE AMOUNTS

- [\*- **If medical care is received from PPO Providers:** [You pay a single [\$500] per individual Deductible each calendar year (or [\$1500] per family, but not counting more than [\$500] for any one person). After you satisfy the Deductible, We will pay Covered Charges at the rate of payment shown above.]
- \*[- **If medical care is received from Non-PPO Providers:** You pay a single [\$1500] per individual Deductible each calendar year (or [\$4,500] per family, but not counting more than [\$1500] for any one person). After you satisfy the Deductible, We will pay Covered Charges at the rate of payment shown above.]
- [\*- You pay a [single] [\$500] per individual Deductible each calendar year [(or[ \$1500] per family, but not counting more than [\$500] for any one person)]. After you satisfy the Deductible, We will pay Covered Charges at the rate of payment shown above.]

[Covered Charges used to satisfy the individual and family maximum calendar year Deductibles that apply when care is received from PPO Providers will [not] be used to satisfy the individual and family maximums that apply when care is received from Non-PPO Providers and vice versa.]

## [OUT-OF-POCKET EXPENSE MAXIMUMS (for each calendar year):

	<u>PPO Providers</u>	<u>Non-PPO Providers</u>
<b>Per Person</b> .....	[\$3,000]	[\$4,500]
<b>Per Family</b> .....	[\$6,000]	[\$9,000]

- [- Covered Charges used to satisfy the Out-of-Pocket Expense limits that apply when care is received from a PPO provider will [not] be used to satisfy the Out-of-Pocket Expense limits that apply when care is received from a Non-PPO Provider and vice versa.]
- If the amount you pay for Covered Charges in any one calendar year reaches the Out-of-Pocket Expense Maximum shown above, We will pay 100% of additional Covered Charges [(except as described above under "Copay Amounts")].

The following charges will not count toward satisfaction of the Out-of-Pocket Expense Maximum:

- Covered Charges for which no benefits are payable because of the Utilization Management penalty; or
- [- The Hospital Services Hospital per admission Copay amount; or]
- [- The Physician Office or Clinic Services per-visit Copay amount; or]

[- The emergency room per-visit Copay amount[/./[/; or]

[- Covered Charges for Mental Health or Behavioral Treatment Services.]

[For Physician Office or Clinic Services Covered Charges [for Treatment or Service received from Non-PPO Providers]: the coinsurance amount you pay in excess of the per-visit Copay amount will be counted toward satisfaction of the Out-of-Pocket Expense Maximum shown, but will not be counted toward satisfaction of the calendar year Deductible.]]

**[COINSURANCE MAXIMUMS (for each calendar year):**

	<b><u>PPO Providers</u></b>	<b><u>Non-PPO Providers</u></b>
<b>Per Person</b> .....	[\$3,000]	[\$5,000]
<b>Per Family</b> .....	[\$5,000]	[\$10,000]

“Coinsurance” means the percentage of Covered Charges shared by you or your Dependents and by Us after the copay and calendar year Deductible have been met.

“Coinsurance Maximum” means the maximum amount of Covered Charges that you or your Dependents must pay in excess of the calendar year Deductible amount.

- [- Covered Charges used to satisfy the Coinsurance Maximums that apply when care is received from a PPO provider will [not] be used to satisfy the Coinsurance Maximums that apply when care is received from a Non-PPO Provider and vice versa.]
- If the amount you pay for Covered Charges in any one calendar year reaches the Coinsurance Maximum shown above, We will pay 100% of additional Covered Charges [(except as described above under "Copay Amounts")].

The following charges will not count toward satisfaction of the Coinsurance Maximum:

- Covered Charges for which no benefits are payable because of the Utilization Management penalty; or
- [- The Hospital Services Hospital per admission Copay amount; or]
- [- The Physician Office or Clinic Services per-visit Copay amount; or]
- [- The emergency room per-visit Copay amount; or]
- [- Covered Charges for Mental Health or Behavioral Treatment Services; or]
- [- The calendar year Deductible.]

[For Physician Office or Clinic Services Covered Charges [for Treatment or Service received from Non-PPO Providers]: the coinsurance amount you pay in excess of the per-visit Copay amount will be counted toward satisfaction of the Coinsurance Maximum shown, but will not be counted toward satisfaction of the calendar year Deductible.]]

**The following exceptions apply to the Benefits Payable provisions described above:**

- [- For medical care received from Non-PPO Providers: [Hospital Inpatient Confinement Charges] [Surgery Related Charges ] and [all charges incurred for services listed in this booklet under Pretreatment Review], benefits payable will be [reduced by [25%] (but not more than [\$2,000] per individual each calendar year)] unless the Utilization Management Requirements are satisfied.] **See page GH 407 CC for a complete description of the Utilization Management Program.**
- [- [For *payment conditions applicable to* [Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services]/[*Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services*], **see page GH 411 B.**]
- [- For payment conditions applicable to Transplant Services, see page GH 411 C.]
- [- For payment conditions applicable to emergency room treatment, see page GH 411 H.]
- [- For payment conditions applicable to Rehabilitative Services, see page GH 411 F.]
- [- For payment conditions applicable to outpatient x-ray services, see page GH 411 G.]
- [- For payment conditions applicable to Wellness Services, see page GH 411 E]
- [- For payment conditions applicable to outpatient Laboratory Services, see page GH 411 G.]
- [- For payment conditions applicable to Medical Emergency, see page GH 411 D.]

**If you [or one of your Dependents] are referred to another provider, you [or your Dependent] should verify with the Physician that the referral is for a PPO Provider. Examples of this would be an [anesthesiologist], x-ray facilities, surgeons, [radiologists], etc. If that provider is not a PPO Provider, the level of benefits for Non-PPO Providers will apply.**

**BENEFIT MAXIMUMS**

[Overall Lifetime] Maximum Payment Limit..... [\$2,000,000][Unlimited]

As described below, there are other Lifetime Maximum Payment Limits applicable to certain medical Treatments or Service. Benefits paid toward all such limits will be counted towards the Overall Lifetime Maximum Payment Limit shown above, and will reduce this maximum accordingly.

[Alcohol or Drug Abuse Treatment or Service See GH 411 B.]

Transplant Services Outside the Transplant Network .....	[\$500,000 during an insured person's lifetime]
Ambulance Services.....	[\$5,000] per person/per calendar year
Home Health Care.....	[40 visits] per person/per calendar year
Prosthetics .....	[\$25,000] during an insured person's lifetime
Skilled Nursing Facility Confinement .....	[\$800 per day/60 days] for all confinements resulting from the same sickness or injury
Durable Medical Equipment .....	[\$2,500] per person/per calendar year

### **Your Responsibilities**

- **If you use providers outside the PPO network**, your medical ID card includes a toll-free telephone number to call for Hospital Admission Review [Pretreatment Review] approvals. You must follow all of the requirements described on page GH 407 CC -- Utilization Management Program or your benefits will be reduced.
- **If you use providers within the PPO network**, your PPO Physician automatically handles the Hospital Admission Review approvals.

**See page GH 146 A for important claim procedures information on filing your medical claims.**

- **Prior approval** is also required for certain other services, including, but not limited to:
  - Home Health Care Services
  - Home Infusion Therapy Services
  - Skilled Nursing Facility Confinement

**Refer to the Description of Benefits section for specific details on the preapproval requirements for these services.**

### **[PRESCRIPTION DRUGS]**

#### **Benefits Payable**

For each prescription and each refill..... [100%] of Covered Charges in excess of the Copay Amount.

This variable used if plan includes Maintenance Drugs and Medicines under the Retail Drug Benefit.



**[Copay Amount For Maintenance Drugs and Medicines:**

An amount equal to [3-times] the applicable Copay amount shown below for "all other drugs".]

**Copay Amount [for All other Drugs]**

This variable used if plan has flat Copay amount:

[For each prescription and each refill ..... [\$5]]

This variable used if plan has dual Copay (i.e., Generic vs Brand Name):

[For each prescription and each refill:

- For Tier 1 Prescription Drugs: ..... [\$5]
- For Tier 2 Prescription Drugs: ..... [\$10] plus [10% ] of the amount of remaining Covered Charges.]]
- [- For Tier 3 Prescription Drugs: ..... [\$15] plus [15% ] of the amount of remaining Covered Charges.]]
- [- For Tier 4 Prescription Drugs: ..... [\$20] plus [20% ] of the amount of remaining Covered Charges.]]
- [- For Tier 5 Prescription Drugs: ..... [\$25] plus [25% ] of the amount of remaining Covered Charges.]]
- [- For Tier 6 Prescription Drugs: ..... [\$30] plus [35% ] of the amount of remaining Covered Charges.]]

**[Prescription Drugs Deductible and Copay Amount**

The individual Deductible and Copay amount for you and each of your Dependents is:

- The first [\$100] of Prescription Drugs Covered Charges incurred each calendar year; followed by
  - [- A Copay of [\$20] for each prescription and each refill.]
  - [- For each prescription and each refill, a Copay of:
    - [\$10] for Tier 1 Prescription Drugs, and
    - [\$20] for Tier2 Prescription Drugs]; and
    - [- [\$25] for Tier3 Prescription Drugs]; and]
    - [- [\$30] for Tier 4 Prescription Drugs]; and]
    - [- [\$35] for Tier 5 Prescription Drugs; and]
    - [- [\$40] for Tier 6 Prescription Drugs.]

[For each prescription and each refill, a Copay of:

- For Tier 1 Prescription Drugs ..... [\$7]
- For Tier 2  
Prescription Drugs ..... [\$10] plus [15%] of the remaining Covered Charges]
- For Tier 3  
Prescription Drugs  
and all other drugs..... [\$15] plus [30%] of the remaining Covered Charges]]
- [- For Tier 4  
Prescription Drugs  
and all other drugs..... [\$20] plus [30%] of the remaining Covered Charges]]
- [- For Tier 5  
Prescription Drugs  
and all other drugs..... [\$25] plus [30%] of the remaining Covered Charges]]
- [- For Tier 6  
Prescription Drugs  
and all other drugs..... [\$30] plus [30%] of the remaining Covered Charges]]

Charges incurred under the Comprehensive Medical benefits cannot be used to satisfy the Prescription Drugs Deductible amount and vice versa.

In addition, charges incurred under this section for Prescription Drugs cannot be used to satisfy the Comprehensive Medical Out-of-Pocket Expense limits.]

If a prescription or refill is not in a select class with a Reference Drug Price:

[Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a Generic equivalent available. When a Brand name drug is dispensed but a generic equivalent was available (including situations where the Physician has specified that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription), the Member [or Dependent] must pay the difference between the Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the Brand Name Drug will apply.]

[Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. Whenever a Brand Name Drug is dispensed but a generic equivalent was available, the Member [or Dependent] must pay the difference between the Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. However, if the physician specifies that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription, benefits will be payable based on the Brand Name Drug pricing after payment of the applicable tier Copay for the Brand Name Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the.] Brand Name Drug will apply.

[If a prescription or refill is in a select class with a Reference Drug Price:

[When a drug is dispensed and the drug price is more than the Reference Drug Price (including situations where the Physician has specified that the medication must be "Dispensed as Written" on the prescription), the Member [or Dependent] must pay the difference between the Reference Drug Price and the price of the drug dispensed in addition to the applicable tier Copay. If the Reference Drug is dispensed, the Member [or Dependent] will pay the applicable tier Copay depending on the drug tier classification.]

[When a drug is dispensed and the drug price is more than the Reference Drug Price and the Physician has specified that the medication must be "Dispensed as Written" on the prescription), the Member [or Dependent] must pay the applicable tier Copay for the drug dispensed. If the Member requests that a drug be dispensed that is more costly than the Reference Drug Price, the Member [or Dependent] must pay the difference between the Reference Drug Price and the price of the drug dispensed in addition to the applicable tier Copay of the drug dispensed. If the Reference Drug is dispensed, the Member [or Dependent] will pay the applicable tier Copay depending on the drug tier classification.]

**[You will receive a list from Us showing those drugs that are included on the Preferred Brand Name Drugs list. When you receive a prescription from your Physician, you should encourage the Physician to prescribe one of the drugs from the list. Explain that your drug cost is significantly lower when you use a Preferred Brand Name Drug. Your employer also has a copy of this list.]**

**See page GH 432 for a complete description of Prescription Drugs Expense Insurance.]**

## **[MAIL SERVICE PRESCRIPTION DRUGS**

### **Benefits Payable**

For each prescription and each refill ..... [100%] of charges in excess of the Copay Amount

## **[Copay Amount**

This variable used if plan has flat Copay amount:

[For each prescription and each refill ..... [\$10]]

This variable used if plan has dual Copay (i.e. Generic vs. Brand Name):

[For each prescription and each refill:

- [- For Tier 1 Prescription Drugs ..... [\$10]
- [- For Tier 2  
Prescription Drugs ..... [\$20] [plus [10%] of the remaining amount  
charged]]
- [- For Tier 3  
Prescription Drugs ..... [\$25] [plus [20%] of the remaining amount  
charged]]
- [- For Tier 4  
Prescription Drugs ..... [\$30] [plus [25%] of the remaining amount  
charged]]
- [- For Tier 5  
Prescription Drugs ..... [\$35] [plus [30%] of the remaining amount  
charged]]
- [- For Tier 6  
Prescription Drugs ..... [\$40] [plus [35%] of the remaining amount  
charged]]

## **[Prescription Drugs Deductible and Copay Amount**

The individual Deductible and Copay amount for you and each of your Dependents is:

- The first [\$100] of Prescription Drugs Covered Charges incurred each calendar year;  
followed by

[-A Copay of [\$20] for each prescription and each refill.]

[-For each prescription and each refill, a Copay of:

- [\$10] for Tier 1 Prescription Drugs, and
- [\$20] for Tier 2 Prescription Drugs]; and ]
- [\$25] for Tier 3 Prescription Drugs]; and]
- [\$30] for Tier 4 Prescription Drugs]; and]
- [\$35] for Tier 6 Prescription Drugs]

[For each prescription and each refill, a Copay of:

- For Tier 1 Prescription Drugs ..... [\$7]
- For Tier 2  
Prescription Drugs ..... [\$10] plus [15%] of the remaining amount charged]
- For Tier 3  
Prescription Drugs  
and all other drugs..... [\$15] plus [30%] of the remaining amount charged]
- [- For Tier 4  
Prescription Drugs  
and all other drugs..... [\$20] plus [35%] of the remaining amount charged]]
- [- For Tier 5  
Prescription Drugs  
and all other drugs..... [\$25] plus [40%] of the remaining amount charged]]
- [- For Tier 6  
Prescription Drugs  
and all other drugs..... [\$30] plus [45%] of the remaining amount charged]]

Charges incurred under the Comprehensive Medical benefits cannot be used to satisfy the Prescription Drugs Deductible amount and vice versa.

In addition, charges incurred under this section for Prescription Drugs cannot be used to satisfy the Comprehensive Medical Out-of-Pocket Expense limits.]

If a prescription or refill is not in a select class with a Reference Drug Price:

[Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a Generic equivalent available. When a Brand name drug is dispensed but a generic equivalent was available (including situations where the Physician has specified that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription), the Member [or Dependent] must pay the difference between the Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the Brand Name Drug will apply.]

[Each prescription and each refill will be filled with a Generic Prescription Drug, if there is a generic equivalent available. Whenever a Brand Name Drug is dispensed but a generic equivalent was available, the Member [or Dependent] must pay the difference between the Generic Drug price and the Brand Name Drug price in addition to the applicable tier Copay for the Brand Drug. However, if the physician specifies that the medication prescribed must be a Brand Name Drug and has indicated "Dispense as Written" on the prescription, benefits will be payable based on the Brand Name Drug pricing after payment of the applicable tier Copay for the Brand Name Drug. If there is no generic equivalent available and a Brand Name Drug is dispensed, the applicable tier Copay of the.] Brand Name Drug will apply.

[If a prescription or refill is in a select class with a Reference Drug Price:

[When a drug is dispensed and the drug price is more than the Reference Drug Price (including situations where the Physician has specified that the medication must be "Dispensed as Written" on the prescription), the Member [or Dependent] must pay the difference between the Reference Drug Price and the price of the drug dispensed in addition to the applicable tier Copay. If the Reference Drug is dispensed, the Member [or Dependent] will pay the applicable tier Copay depending on the drug tier classification.]

[When a drug is dispensed and the drug price is more than the Reference Drug Price and the Physician has specified that the medication must be "Dispensed as Written" on the prescription), the Member [or Dependent] must pay the applicable tier Copay for the drug dispensed. If the Member requests that a drug be dispensed that is more costly than the Reference Drug Price, the Member [or Dependent] must pay the difference between the Reference Drug Price and the price of the drug dispensed in addition to the applicable tier Copay of the drug dispensed. If the Reference Drug is dispensed, the Member [or Dependent] will pay the applicable tier Copay depending on the drug tier classification.]

**[You will receive a list from Us showing those drugs that are included on the Preferred Brand Name Drugs list. When you receive a prescription from your Physician, you should encourage the Physician to prescribe one of the drugs from the list. Explain that your drug cost is significantly lower when you use a Preferred Brand Name Drug. Your employer also has a copy of this list.]**

**See page GH 433 for a complete description of Mail Service Prescription Drugs Expense Insurance.]**

## **DESCRIPTION OF BENEFITS**

### **MEDICAL EXPENSE INSURANCE**

***/MENTAL HEALTH OR BEHAVIORAL TREATMENT SERVICES AND ALCOHOL OR DRUG ABUSE TREATMENT SERVICES//MENTAL HEALTH, BEHAVIORAL, ALCOHOL OR DRUG ABUSE TREATMENT SERVICES/***

#### **Benefits Payable**

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- all Payment Provisions described in GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, [Medicare Carveout] and [Subrogation and Reimbursement].

#### **[Benefits Payable - Mental Health or Behavioral Treatment Services or Alcohol or Drug Abuse Treatment Services**

The following benefits will be payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. These benefits will be payable instead of any other benefits described in this booklet, except as otherwise indicated in this section. In the event you [or one of your Dependents] receive Treatment or Services for more than one condition during the same period of time, benefits will be payable based on the primary focus of the Treatment or Service, as determined by Us.

- **Mental Health or Behavioral Treatment Services**
  - **Inpatient Hospital Services**

If you [or one of your Dependents] are Hospital Inpatient Confined in a Psychiatric Hospital, a psychiatric unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.

Benefits will be payable as described below.

#### **(2) Partial Hospitalization or Day Treatment Services**

If you [or one of your Dependents] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described below.

"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital, a Psychiatric Hospital, a licensed outpatient psychiatric center, a Community Mental Health Center, or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment

Services.

"Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health or Behavioral Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

- **Outpatient Services**

If you [or one of your Dependents] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Psychiatric Hospital, outpatient psychiatric center, or Community Mental Health Center, benefits will be payable as described below.

"Outpatient Services" mean Mental Health or Behavioral Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.

Covered Charges for Outpatient Services are limited to the following services:

- crisis intervention or stabilization;
- psychological testing;
- individual psychotherapy;
- family therapy;
- group therapy;
- electroconvulsive therapy;
- psychiatric medication management;
- [- biofeedback;]
- behavior modification treatment;
- [- hypnotherapy;]
- narcosynthesis.

- **Physician Visits**

If you [or one of your Dependents] receives any Mental Health or Behavioral Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:

- **While Hospital Inpatient Confined:** Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described below.
- **While Receiving Partial Hospitalization or Day Treatment Services:** Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described below.



- **All Other Physician Visits:** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services are Outpatient Services and will be payable as described below. Covered services will be those listed under Outpatient Services above.
- **Benefits Payable**
  - **Inpatient Hospital Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible that applies to any other Inpatient Hospital Confinement, as well as the calendar year maximum benefit described below.  
  
[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by Us for Inpatient Hospital Confinement will not be considered Covered Charges.]
  - **Partial Hospitalization or Day Treatment Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the calendar year Deductible, as well as the calendar year maximum benefit described below.
  - **Outpatient Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible that applies to any other outpatient services, as well as the calendar year maximum benefit described below.
  - **Physician Visits:** Benefits will be payable at [80%] of Covered Charges and will be subject to the calendar year Deductible, as well as the calendar year maximum benefit described below.

The [80%] coinsurance rate described above applies whether or not you [or your Dependents] has satisfied the Out-of-Pocket Expense limit described in GH 104 B.

- **Calendar Year Maximum**  
  
The maximum benefit payable for any combination of Covered Charges described above will be limited to a maximum benefit of [\$7,500] each calendar year for each insured person.
- ***Alcohol or Drug Abuse Treatment Services***
  - ***Inpatient Hospital Services***  
  
*If you [or one of your Dependents] are Hospital Inpatient confined in an Inpatient Alcohol or Drug Abuse Treatment Facility or an alcohol/drug unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.*

*Benefits will be payable as described below.*

- ***Partial Hospitalization or Day Treatment Services***

*If you [or one of your Dependents] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described below.*

*"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

*"Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provided diagnostic and therapeutic Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.*

- ***Outpatient Services***

*If you [or one of your Dependents] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, or Outpatient Alcohol or Drug Abuse Treatment Facility, benefits will be payable as described below.*

*"Outpatient Services" mean Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.*

*Covered Charges for Outpatient Services are limited to the following services:*

- *individual therapy;*
- *family therapy;*
- *group therapy;*
- *alcohol or drug abuse medication management;*
- *biofeedback;*
- *behavior modification treatment;*
- *alcohol or drug abuse rehabilitation or counseling services.*

- ***Physician Visits***

*If you [or one of your Dependents] receives any Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:*

- ***While Hospital Inpatient Confined:*** *Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described below.*
- ***While Receiving Partial Hospitalization or Day Treatment Services:*** *Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment*

*Services benefits are payable. Benefits will be payable as described below.*

- ***All Other Physician Visits:*** *Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services will be considered Outpatient Services and will be payable as described below. Covered services will be those listed under Outpatient Services above.*

- ***Benefits Payable***

- ***Inpatient Hospital Services:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible that applies to any other Inpatient Hospital Confinement, as well as the Maximum Benefits described below.*

*[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by Us for Inpatient Hospital Confinement will not be considered Covered Charges.]*

- ***Partial Hospitalization or Day Treatment Services:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the calendar year Deductible, as well as the Maximum Benefits described below.*
- ***Outpatient Services:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible that applies to any other outpatient services, as well as the Maximum Benefits described below.*
- ***Physician Visits:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the calendar year Deductible, as well as the Maximum Benefits described below.*

- ***Maximum Benefits***

*For each insured person, the maximum benefit payable for any combination of Covered Charges described above will be limited to:*

- *[\$6,000] during any period of [two] consecutive calendar years; and*
- *[\$12,000] during the insured person's lifetime.*

- ***Provisions Applicable to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services***

*For the purpose of the benefits described in this section:*

- *No benefits will be payable for any charges incurred in excess of the limits and maximums described in this section. The general Comprehensive Medical limitations, as described in GH 411 O (HDHP), will apply to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. In*

*addition, Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:*

- *recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or*
  - *psychoanalysis and aversion therapy; or*
  - *residential mental health or behavioral Treatment or Service; or*
  - *after-care treatment programs for alcohol or drug abuse.*
- [- Benefits payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit, and this maximum will be reduced by the benefits paid.]*
- *Covered Charges incurred for outpatient laboratory services and for outpatient drugs and medicines requiring a Physician's prescription are payable the same as for any other covered Treatment or Service, and are not subject to the limits described above.*
- [- Charges for Outpatient Services or Partial Hospitalization or Day Treatment Services that are in excess of those approved by The Principal for Outpatient Services or for Partial Hospitalization or Day Treatment Services will not be considered Covered Charges.]*
- [- Benefits payable for Outpatient Services and Partial Hospitalization or Day Treatment Services will be reduced by [25%] unless the Utilization Management Requirements described in GH 407 CC are satisfied.]]*

#### **[Benefits Payable - Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]**

The following benefits will be payable for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. *In the event you [or one of your Dependents] receive Treatment or Services for more than one condition during the same period of time, benefits will be payable based on the primary focus of the Treatment or Service, as determined by Us.*

##### **- Inpatient Hospital Services**

*If a Member [or Dependent] is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Alcohol or Drug Abuse Treatment Facility, a psychiatric or alcohol/drug unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement. Benefits are payable the same as for any other Hospital Inpatient Confinement.*

- **Outpatient Services**

If you [or one of your Dependents] receive any Outpatient Services by a Physician or Health Care Extender, Hospital, *Psychiatric Hospital, outpatient psychiatric center, Community Mental Health Center, or Outpatient Alcohol or Drug Abuse Treatment Facility*, benefits will be payable *the same as for any other outpatient services*.

"Outpatient Services" mean Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient *Confined*.

Covered Charges for Outpatient Services are limited to the following services:

- *Partial Hospitalization or Day Treatment Services;*
- crisis intervention or stabilization;
- psychological testing;
- individual psychotherapy;
- family therapy;
- group therapy;
- electroconvulsive therapy;
- psychiatric, alcohol or drug abuse medication management;
- [- biofeedback;]
- behavior modification treatment;
- alcohol or drug abuse rehabilitation or counseling services;
- [- hypnotherapy;]
- narcosynthesis.

*For the purpose of these Outpatient Services benefits, "Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period. "Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

- **Physician Visits**

If you [or one of your Dependents] receive any Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable *the same as for any other Physician Visit*.

- **Benefits Payable**

*Benefits for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services are payable the same as for any other covered Treatment or Service.*

*[Benefits paid will be applied toward the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.]*

*[Charges incurred for Outpatient Services that are in excess of those approved by Us for*

Outpatient *Services will* not be considered Covered Charges.

Benefits payable for Outpatient *Services will* be reduced by [25%] unless the Utilization Management Requirements described on GH 407 CC are satisfied.]

[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by Us for Inpatient Hospital Confinement will not be considered Covered Charges.]

- **Limitations**

*The* general Comprehensive Medical limitations, as described in GH 411 O (HDHP), will apply to Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In addition Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:

- recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or
- psychoanalysis and aversion therapy; or
- residential mental health or behavioral Treatment or Service; or
- after-care treatment programs for alcohol or drug abuse./

## **DESCRIPTION OF BENEFITS**

### **MEDICAL EXPENSE INSURANCE**

***/MENTAL HEALTH OR BEHAVIORAL TREATMENT SERVICES AND ALCOHOL OR DRUG ABUSE TREATMENT SERVICES//MENTAL HEALTH, BEHAVIORAL, ALCOHOL OR DRUG ABUSE TREATMENT SERVICES/***

#### **Benefits Payable**

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- all Payment Provisions described in GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, [Medicare Carveout] and [Subrogation and Reimbursement].

#### **[Benefits Payable - Mental Health or Behavioral Treatment Services or Alcohol or Drug Abuse Treatment Services**

The following benefits will be payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. These benefits will be payable instead of any other benefits described in this booklet, except as otherwise indicated in this section. In the event you [or one of your Dependents] receive Treatment or Services for more than one condition during the same period of time, benefits will be payable based on the primary focus of the Treatment or Service, as determined by Us.

- **Mental Health or Behavioral Treatment Services**
  - **Inpatient Hospital Services**

If you [or one of your Dependents] are Hospital Inpatient Confined in a Psychiatric Hospital, a psychiatric unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.

Benefits will be payable as described below.

#### **(2) Partial Hospitalization or Day Treatment Services**

If you [or one of your Dependents] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described below.

"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital, a Psychiatric Hospital, a licensed outpatient psychiatric center, a Community Mental Health Center, or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment

Services.

"Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health or Behavioral Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

- **Outpatient Services**

If you [or one of your Dependents] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Psychiatric Hospital, outpatient psychiatric center, or Community Mental Health Center, benefits will be payable as described below.

"Outpatient Services" mean Mental Health or Behavioral Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.

Covered Charges for Outpatient Services are limited to the following services:

- crisis intervention or stabilization;
- psychological testing;
- individual psychotherapy;
- family therapy;
- group therapy;
- electroconvulsive therapy;
- psychiatric medication management;
- [- biofeedback;]
- behavior modification treatment;
- [- hypnotherapy;]
- narcosynthesis.

- **Physician Visits**

If you [or one of your Dependents] receives any Mental Health or Behavioral Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:

- **While Hospital Inpatient Confined:** Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described below.
- **While Receiving Partial Hospitalization or Day Treatment Services:** Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described below.



- **All Other Physician Visits:** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services are Outpatient Services and will be payable as described below. Covered services will be those listed under Outpatient Services above.

- **Benefits Payable**

- **Inpatient Hospital Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible or Copay that applies to any other Inpatient Hospital Confinement, as well as the calendar year maximum benefit described below.

[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by Us for Inpatient Hospital Confinement will not be considered Covered Charges.]

- **Partial Hospitalization or Day Treatment Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the calendar year Deductible, as well as the calendar year maximum benefit described below.
- **Outpatient Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible or Copay that applies to any other outpatient services, as well as the calendar year maximum benefit described below.
- **Physician Visits:** Benefits will be payable at [80%] of Covered Charges and will be subject to [any applicable per-visit Copay][the calendar year Deductible], as well as the calendar year maximum benefit described below.

The [80%] coinsurance rate described above applies whether or not you [or your Dependents] has satisfied the Out-of-Pocket Expense limit described in GH 104 B.

- **Calendar Year Maximum**

The maximum benefit payable for any combination of Covered Charges described above will be limited to a maximum benefit of [\$7,500] each calendar year for each insured person.

- ***Alcohol or Drug Abuse Treatment Services***

- ***Inpatient Hospital Services***

*If you [or one of your Dependents] are Hospital Inpatient confined in an Inpatient Alcohol or Drug Abuse Treatment Facility or an alcohol/drug unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.*

*Benefits will be payable as described below.*

- ***Partial Hospitalization or Day Treatment Services***

*If you [or one of your Dependents] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described below.*

*"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

*"Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provided diagnostic and therapeutic Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.*

- ***Outpatient Services***

*If you [or one of your Dependents] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, or Outpatient Alcohol or Drug Abuse Treatment Facility, benefits will be payable as described below.*

*"Outpatient Services" mean Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.*

*Covered Charges for Outpatient Services are limited to the following services:*

- *individual therapy;*
- *family therapy;*
- *group therapy;*
- *alcohol or drug abuse medication management;*
- *biofeedback;*
- *behavior modification treatment;*
- *alcohol or drug abuse rehabilitation or counseling services.*

- ***Physician Visits***

*If you [or one of your Dependents] receives any Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:*

- ***While Hospital Inpatient Confined:*** *Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described below.*
- ***While Receiving Partial Hospitalization or Day Treatment Services:*** *Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they*

*occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described below.*

- ***All Other Physician Visits:*** *Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services will be considered Outpatient Services and will be payable as described below. Covered services will be those listed under Outpatient Services above.*

- ***Benefits Payable***

- ***Inpatient Hospital Services:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible that applies to any other Inpatient Hospital Confinement, as well as the Maximum Benefits described below.*

*[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by Us for Inpatient Hospital Confinement will not be considered Covered Charges.]*

- ***Partial Hospitalization or Day Treatment Services:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the calendar year Deductible, as well as the Maximum Benefits described below.*
- ***Outpatient Services:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible that applies to any other outpatient services, as well as the Maximum Benefits described below.*
- ***Physician Visits:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the calendar year Deductible, as well as the Maximum Benefits described below.*

- ***Maximum Benefits***

*For each insured person, the maximum benefit payable for any combination of Covered Charges described above will be limited to:*

- *[\$6,000] during any period of [two] consecutive calendar years; and*
- *[\$12,000] during the insured person's lifetime.*

- ***Provisions Applicable to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services***

*For the purpose of the benefits described in this section:*

- *No benefits will be payable for any charges incurred in excess of the limits and maximums described in this section. The general Comprehensive Medical limitations, as described in GH 411 O, will apply to Mental Health or Behavioral*

*Treatment Services and Alcohol or Drug Abuse Treatment Services. In addition, Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:*

- *recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or*
  - *psychoanalysis and aversion therapy; or*
  - *residential mental health or behavioral Treatment or Service; or*
  - *after-care treatment programs for alcohol or drug abuse.*
- [- Benefits payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit, and this maximum will be reduced by the benefits paid.]*
- *Covered Charges incurred for outpatient laboratory services and for outpatient drugs and medicines requiring a Physician's prescription are payable the same as for any other covered Treatment or Service, and are not subject to the limits described above.*
- [- Charges for Outpatient Services or Partial Hospitalization or Day Treatment Services that are in excess of those approved by The Principal for Outpatient Services or for Partial Hospitalization or Day Treatment Services will not be considered Covered Charges.]*
- [- Benefits payable for Outpatient Services and Partial Hospitalization or Day Treatment Services will be reduced by [25%] unless the Utilization Management Requirements described in GH 407 CC are satisfied.]]*

**[Benefits Payable - Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]**

The following benefits will be payable for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In the event you [or one of your Dependents] receive Treatment or Services for more than one condition during the same period of time, benefits will be payable based on the primary focus of the Treatment or Service, as determined by Us.

**- Inpatient Hospital Services**

If a Member [or Dependent] is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Alcohol or Drug Abuse Treatment Facility, a psychiatric or alcohol/drug unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement. *Benefits are payable the same as for any other Hospital Inpatient Confinement.*

- **Outpatient Services**

If you [or one of your Dependents] receive any Outpatient Services by a Physician or Health Care Extender, Hospital, *Psychiatric Hospital, outpatient psychiatric center, Community Mental Health Center, or Outpatient Alcohol or Drug Abuse Treatment Facility*, benefits will be payable *the same as for any other outpatient services*.

"Outpatient Services" mean Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient *Confined*.

Covered Charges for Outpatient Services are limited to the following services:

- *Partial Hospitalization or Day Treatment Services;*
- crisis intervention or stabilization;
- psychological testing;
- individual psychotherapy;
- family therapy;
- group therapy;
- electroconvulsive therapy;
- psychiatric, alcohol or drug abuse medication management;
- [- biofeedback;]
- behavior modification treatment;
- alcohol or drug abuse rehabilitation or counseling services;
- [- hypnotherapy;]
- narcosynthesis.

*For the purpose of these Outpatient Services benefits, "Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period. "Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

- **Physician Visits**

If you [or one of your Dependents] receive any Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable *the same as for any other Physician Visit*.

- **Benefits Payable**

*Benefits for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services are payable the same as for any other covered Treatment or Service.*

*[Benefits paid will be applied toward the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.]*

[Charges incurred for Outpatient Services *that* are in excess of those approved by Us for

Outpatient *Services will* not be considered Covered Charges.

Benefits payable for Outpatient *Services will* be reduced by [25%] unless the Utilization Management Requirements described on GH 407 CC are satisfied.]

[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by Us for Inpatient Hospital Confinement will not be considered Covered Charges.]

- **Limitations**

*The* general Comprehensive Medical limitations, as described in GH 411 O, will apply to Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In addition Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:

- recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or
- psychoanalysis and aversion therapy; or
- residential mental health or behavioral Treatment or Service; or
- after-care treatment programs for alcohol or drug abuse./

## **DESCRIPTION OF BENEFITS**

### **MEDICAL EXPENSE INSURANCE**

#### ***/MENTAL HEALTH OR BEHAVIORAL TREATMENT SERVICES AND ALCOHOL OR DRUG ABUSE TREATMENT SERVICES//MENTAL HEALTH, BEHAVIORAL, ALCOHOL OR DRUG ABUSE TREATMENT SERVICES/***

#### **Benefits Payable**

Benefits payable will be as described in this section, subject to:

- all listed limitations; and
- all Payment Provisions described in GH 410; and
- the terms and conditions of Utilization Management Program, Coordination With Other Benefits, [Medicare Carveout] and [Subrogation and Reimbursement].

#### **[Benefits Payable - Mental Health or Behavioral Treatment Services or Alcohol or Drug Abuse Treatment Services**

The following benefits will be payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. These benefits will be payable instead of any other benefits described in this booklet, except as otherwise indicated in this section. In the event you [or one of your Dependents] receive Treatment or Services for more than one condition during the same period of time, benefits will be payable based on the primary focus of the Treatment or Service, as determined by Us.

- **Mental Health or Behavioral Treatment Services**
  - **Inpatient Hospital Services**

If you [or one of your Dependents] are Hospital Inpatient Confined in a Psychiatric Hospital, a psychiatric unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.

Benefits will be payable as described below.

#### **(2) Partial Hospitalization or Day Treatment Services**

If you [or one of your Dependents] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described below.

"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital, a Psychiatric Hospital, a licensed outpatient psychiatric center, a Community Mental Health Center, or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment

Services.

"Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health or Behavioral Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.

- **Outpatient Services**

If you [or one of your Dependents] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, Psychiatric Hospital, outpatient psychiatric center, or Community Mental Health Center, benefits will be payable as described below.

"Outpatient Services" mean Mental Health or Behavioral Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.

Covered Charges for Outpatient Services are limited to the following services:

- crisis intervention or stabilization;
- psychological testing;
- individual psychotherapy;
- family therapy;
- group therapy;
- electroconvulsive therapy;
- psychiatric medication management;
- [- biofeedback;]
- behavior modification treatment;
- [- hypnotherapy;]
- narcosynthesis.

- **Physician Visits**

If you [or one of your Dependents] receives any Mental Health or Behavioral Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:

- **While Hospital Inpatient Confined:** Benefits will be payable for Physician Visits when provided while the person is Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described below.
- **While Receiving Partial Hospitalization or Day Treatment Services:** Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment Services benefits are payable. Benefits will be payable as described below.



- **All Other Physician Visits:** Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services are Outpatient Services and will be payable as described below. Covered services will be those listed under Outpatient Services above.

- **Benefits Payable**

- **Inpatient Hospital Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible or Copay that applies to any other Inpatient Hospital Confinement, as well as the calendar year maximum benefit described below.

[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by Us for Inpatient Hospital Confinement will not be considered Covered Charges.]

- **Partial Hospitalization or Day Treatment Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the calendar year Deductible, as well as the calendar year maximum benefit described below.
- **Outpatient Services:** Benefits will be payable at [80%] of Covered Charges and will be subject to the same Deductible or Copay that applies to any other outpatient services, as well as the calendar year maximum benefit described below.
- **Physician Visits:** Benefits will be payable at [80%] of Covered Charges and will be subject to [any applicable per-visit Copay][the calendar year Deductible], as well as the calendar year maximum benefit described below.

The [80%] coinsurance rate described above applies whether or not you [or your Dependents] has satisfied the Out-of-Pocket Expense limit described in GH 104A.

- **Calendar Year Maximum**

The maximum benefit payable for any combination of Covered Charges described above will be limited to a maximum benefit of [\$7,500] each calendar year for each insured person.

- ***Alcohol or Drug Abuse Treatment Services***

- ***Inpatient Hospital Services***

*If you [or one of your Dependents] are Hospital Inpatient confined in an Inpatient Alcohol or Drug Abuse Treatment Facility or an alcohol/drug unit of a general Hospital, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement.*

*Benefits will be payable as described below.*

- ***Partial Hospitalization or Day Treatment Services***

*If you [or one of your Dependents] receives Partial Hospitalization or Day Treatment Services, benefits will be payable for such services as described below.*

*"Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

*"Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provided diagnostic and therapeutic Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period.*

- ***Outpatient Services***

*If you [or one of your Dependents] receives any Outpatient Services by a Physician or Health Care Extender, Hospital, or Outpatient Alcohol or Drug Abuse Treatment Facility, benefits will be payable as described below.*

*"Outpatient Services" mean Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient Confined or receiving Partial Hospitalization or Day Treatment Services.*

*Covered Charges for Outpatient Services are limited to the following services:*

- *individual therapy;*
- *family therapy;*
- *group therapy;*
- *alcohol or drug abuse medication management;*
- *biofeedback;]*
- *behavior modification treatment;*
- *alcohol or drug abuse rehabilitation or counseling services.*

- ***Physician Visits***

*If you [or one of your Dependents] receives any Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable as follows:*

- ***While Hospital Inpatient Confined:*** *Benefits will be payable for Physician Visits when provided while the person in Hospital Inpatient Confined, only if they occur during the period for which inpatient Hospital benefits are payable. Benefits will be payable as described below.*
- ***While Receiving Partial Hospitalization or Day Treatment Services:*** *Benefits will be payable for Physician Visits when provided while the person is receiving Partial Hospitalization or Day Treatment Services, only if they occur during the period for which Partial Hospitalization or Day Treatment*

*Services benefits are payable. Benefits will be payable as described below.*

- ***All Other Physician Visits:*** *Benefits for Physician Visits provided other than while Hospital Inpatient Confined or while receiving Partial Hospitalization or Day Treatment Services will be considered Outpatient Services and will be payable as described below. Covered services will be those listed under Outpatient Services above.*

- ***Benefits Payable***

- ***Inpatient Hospital Services:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible that applies to any other Inpatient Hospital Confinement, as well as the Maximum Benefits described below.*

*[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by Us for Inpatient Hospital Confinement will not be considered Covered Charges.]*

- ***Partial Hospitalization or Day Treatment Services:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the calendar year Deductible, as well as the Maximum Benefits described below.*
- ***Outpatient Services:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the same Deductible that applies to any other outpatient services, as well as the Maximum Benefits described below.*
- ***Physician Visits:*** *Benefits will be payable the same as for any other covered Treatment or Service and will be subject to the calendar year Deductible, as well as the Maximum Benefits described below.*

- ***Maximum Benefits***

*For each insured person, the maximum benefit payable for any combination of Covered Charges described above will be limited to:*

- *[\$6,000] during any period of [two] consecutive calendar years; and*
- *[\$12,000] during the insured person's lifetime.*

- ***Provisions Applicable to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services***

*For the purpose of the benefits described in this section:*

- *No benefits will be payable for any charges incurred in excess of the limits and maximums described in this section. The general Comprehensive Medical limitations, as described in GH 412 O, will apply to Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services. In addition,*

*Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:*

- *recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or*
  - *psychoanalysis and aversion therapy; or*
  - *residential mental health or behavioral Treatment or Service; or*
  - *after-care treatment programs for alcohol or drug abuse.*
- [- Benefits payable for Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services will be applied to the Comprehensive Medical Overall Lifetime Maximum Payment Limit, and this maximum will be reduced by the benefits paid.]*
- *Covered Charges incurred for outpatient laboratory services and for outpatient drugs and medicines requiring a Physician's prescription are payable the same as for any other covered Treatment or Service, and are not subject to the limits described above.*
- [- Charges for Outpatient Services or Partial Hospitalization or Day Treatment Services that are in excess of those approved by The Principal for Outpatient Services or for Partial Hospitalization or Day Treatment Services will not be considered Covered Charges.]*
- [- Benefits payable for Outpatient Services and Partial Hospitalization or Day Treatment Services will be reduced by [25%] unless the Utilization Management Requirements described in GH 407 CC are satisfied.]]*

#### **[Benefits Payable - Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]**

The following benefits will be payable for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In the event you [or one of your Dependents] receive Treatment or Services for more than one condition during the same period of time, benefits will be payable based on the primary focus of the Treatment or Service, as determined by Us.

##### **- Inpatient Hospital Services**

If a Member [or Dependent] is Hospital Inpatient Confined in a Psychiatric Hospital, an Inpatient Alcohol or Drug Abuse Treatment Facility, a psychiatric or alcohol/drug unit of a general Hospital, a licensed outpatient psychiatric center, or a Community Mental Health Center, benefits will be payable for charges for room, board, and other usual services provided during such confinement, and for Physician Visits provided during such confinement. *Benefits are payable the same as for any other Hospital Inpatient Confinement.*

- **Outpatient Services**

If you [or one of your Dependents] receive any Outpatient Services by a Physician or Health Care Extender, Hospital, *Psychiatric Hospital, outpatient psychiatric center, Community Mental Health Center, or Outpatient Alcohol or Drug Abuse Treatment Facility*, benefits will be payable *the same as for any other outpatient services*.

"Outpatient Services" mean Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services, including Physician Visits, which are provided other than while Hospital Inpatient *Confined*.

Covered Charges for Outpatient Services are limited to the following services:

- *Partial Hospitalization or Day Treatment Services;*
- crisis intervention or stabilization;
- psychological testing;
- individual psychotherapy;
- family therapy;
- group therapy;
- electroconvulsive therapy;
- psychiatric, alcohol or drug abuse medication management;
- [- biofeedback;]
- behavior modification treatment;
- alcohol or drug abuse rehabilitation or counseling services;
- [- hypnotherapy;]
- narcosynthesis.

*For the purpose of these Outpatient Services benefits, "Partial Hospitalization or Day Treatment Services" mean a structured program under the supervision of a Physician, which provides diagnostic and therapeutic Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services in a Partial Hospitalization Facility or Day Treatment Facility for not less than four and not more than 12 consecutive hours in a 24-hour period. "Partial Hospitalization Facility or Day Treatment Facility" means a Hospital or freestanding facility that is licensed by the proper authority of the state in which it is located to provide Partial Hospitalization or Day Treatment Services.*

- **Physician Visits**

If you [or one of your Dependents] receive any Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services by a Physician or Health Care Extender, benefits will be payable *the same as for any other Physician Visit*.

- **Benefits Payable**

*Benefits for Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services are payable the same as for any other covered Treatment or Service.*

*[Benefits paid will be applied toward the Comprehensive Medical Overall Lifetime Maximum Payment Limit and this maximum will be reduced by the benefits paid.]*

*[Charges incurred for Outpatient Services that are in excess of those approved by Us for*

Outpatient *Services will* not be considered Covered Charges.

Benefits payable for Outpatient *Services will* be reduced by [25%] unless the Utilization Management Requirements described on GH 407 CC are satisfied.]

[Charges incurred for room, board and other usual services, including Physician Visits, that are in excess of those approved by Us for Inpatient Hospital Confinement will not be considered Covered Charges.]

- **Limitations**

*The* general Comprehensive Medical limitations, as described in GH 412 O, will apply to Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services. In addition Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services will not include and no benefits will be paid for:

- recreational therapy, art therapy, music therapy, dance therapy, or wilderness therapy; or
- psychoanalysis and aversion therapy; or
- residential mental health or behavioral Treatment or Service; or
- after-care treatment programs for alcohol or drug abuse./

## DEFINITIONS

Several words and phrases used to describe your coverage are capitalized whenever they are used in this booklet. These words and phrases have special meanings as explained in this section.

**[Alcohol or Drug Abuse Treatment Services]** means Treatment or Service provided to alter a person's behavior, regardless of the cause of that behavior, including, but not limited to: individual, family or group psychotherapy; psychiatric diagnostic interview or examinations; behavior modification; alcohol or drug abuse medication management; alcohol or drug abuse rehabilitation or counseling services; [biofeedback,] or milieu or other therapies (physical, occupational or speech therapy), used to diagnose or treat alcohol or drug abuse problems].

**Ambulatory Surgery Center** means a facility designed to provide surgical care which does not require Hospital Inpatient Confinement but is at a level above what is available in a Physician's office or clinic. An Ambulatory Surgery Center:

- is licensed by the proper authority in the state in which it is located, has an organized Physician staff, and has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and
- provides Physician services and full-time skilled nursing services directed by a licensed registered nurse (R.N.) whenever a patient is in the facility; and
- does not provide the services or other accommodations for Hospital Inpatient Confinement; and
- is not a facility used as an office or clinic for the private practice of a Physician or other professional providers.

**Average Wholesale Price** means the published cost of a drug product to the wholesaler.

**Birthing Center** means a freestanding facility that is licensed by the proper authority of the state in which it is located and that:

- provides prenatal care, delivery, and immediate postpartum care; and
- operates under the direction of a Physician who is a specialist in obstetrics and gynecology; and
- has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; and
- provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by a licensed registered nurse (R.N.) or certified nurse midwife; and
- has a Written agreement with a Hospital in the area for emergency transfer of a patient or a newborn child, with Written procedures for such transfer being displayed and staff members being aware of such procedures.

**Community Mental Health Center** means a community or county mental health facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient [Mental Health or Behavioral Treatment Services]/[*Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services*].

**[Copayment; Copay]** means a specified dollar amount that must be paid by you[ or a Dependent] each time certain or specified services are rendered. [In no event will the Copay amount exceed:

- for services provided by PPO Providers, the negotiated fee; and
- for services provided by Non-PPO Providers, the actual cost charged to you [or your Dependent].]]

**Cosmetic Treatment and Services** mean Treatment or Services to change:

- the texture or appearance of the skin; or
- the relative size or position of any part of the body;

when such Treatment or Service is performed primarily for psychological purposes or is not needed to correct or improve a bodily function. Cosmetic Treatment and Services include, but are not limited to surgery, pharmacological regimens, and all related charges.

**[Covered Charge]** [Medically Necessary Care] means] a Treatment or Service is considered to be [a Covered Charge] [Medically Necessary Care] if the Treatment or Services is:

- prescribed by a Physician and required for the screening, diagnosis or treatment of a medical condition;
- consistent with the diagnosis or symptoms;
- not excessive in scope, duration, intensity or quantity;
- the most appropriate level of services or supplies that can safely be provided; and
- determined by Us to be Generally Accepted.

**Creditable Coverage** means with respect to an individual, coverage of the individual under any of the following:

- a Group Health Plan, as defined in this section;
- Health Insurance Coverage, as defined in this section;
- Medicare (Part A or Part B of Title XVIII of the Social Security Act);
- Medicaid (Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928);
- TRICARE (Chapter 55 of Title 10, United States Code);



- a medical care program of the Indian Health Service or of a tribal organization;
- a state health benefits risk pool;
- a health benefit plan for government employees (Chapter 89 of Title 5, United States Code);
- a public health plan established or maintained by a State, the United States, a foreign country, or any political subdivision thereof;
- a health benefit plan provided under the Peace Corp Act;
- any other similar coverage permitted under state or federal law or regulations;
- a health benefit plan provided under a State Children's Health Insurance Program (Title XXI of the Social Security Act).

Creditable Coverage does not include coverage consisting solely of coverage of Excepted Benefits. For this purpose, "Excepted Benefits" mean benefits or coverage under one or more (or any combination) of the following:

- coverage only for accident (including accidental death and dismemberment);
- disability income insurance;
- liability insurance, including general liability insurance and automobile liability insurance;
- coverage issued as a supplement to liability insurance;
- Workers' Compensation or similar insurance;
- automobile medical payment insurance;
- credit-only insurance (for example, mortgage insurance);
- coverage for on-site medical clinics;
- other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits;
- the following benefits, if offered separately from medical expense benefits (provided under a separate policy, certificate or contract of insurance, or otherwise not an integral part of the plan):
  - limited scope dental or vision benefits;
  - benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
  - other similar limited benefits;

- the following benefits, if offered as independent, noncoordinated benefits:
  - coverage only for a specified disease or illness;
  - hospital indemnity or other fixed indemnity insurance;
- the following benefits, if offered as a separate insurance policy:
  - Medicare Supplement insurance;
  - coverage supplemental to TRICARE;
  - similar supplemental coverage provided to coverage under a Group Health Plan;
  - health flexible spending arrangement, if the following are satisfied:
    - the maximum benefit from employee and employer contributions for the year does not exceed two times the employee's annual salary reduction;
    - the employee has other group health coverage available that is not limited to Excepted Benefits.

**Custodial Care** means assistance with meeting personal needs or the Activities of Daily Living.

For this purpose, "Activities of Daily Living" means activities that do not require the services of a Physician, registered nurse (R.N.), licensed practical nurse (L.P.N.), chiropractor, physical therapist, occupational therapist, speech therapist or other health care professional including, but not limited to, bathing, dressing, getting in and out of bed, feeding, walking, elimination and taking medications.

**Deductible; Deductible Amount** means a specified dollar amount of Covered Charges that must be incurred by the insured person before benefits will be payable under the Group Policy for all or part of the remaining Covered Charges during the calendar year.

**Dental Services** mean any Treatment or Service provided to diagnose, prevent, or correct:

- periodontal disease (disease of the surrounding and supplemental tissues of the teeth, including deformities of the bone surrounding the teeth); or
- malocclusion (abnormal positioning or relationship of the teeth); or
- ailments or defects of the teeth and supporting tissue and bone (excluding [impacted teeth and] appliances used to close an acquired or congenital opening. However, the term Dental Services will include treatment performed to replace or restore any natural teeth in conjunction with the use of any such appliance).

**[Dependent means:**

- Your spouse, if your spouse:
  - is not in the Armed Forces of any country; [and
  - is not insured under the Group Policy as a Member.]
- Your Dependent Child (or Children) as defined below[.] [;and]
- [- Your Domestic Partner, if you and the Domestic Partner complete and submit a Declaration of Domestic Partnership which is approved by Us].

**[Dependent Child; Dependent Children means:**

- Your natural or legally adopted child, if that child:
  - is not married; and
  - is not in the Armed Forces of any country; and
  - is not insured under the Group Policy as a Member; and
  - is less than 19 years of age.

A newly adopted child will be considered a Dependent Child from the date of Placement with you for the purpose of adoption or the date of adoption, whichever is earlier. The child will continue to be a Dependent Child unless the Placement is disrupted prior to legal adoption and the child is removed from Placement.

- Your stepchild, if that child:
  - meets the requirements above; and
  - receives principal support from you.
- Your foster child, if that child:
  - meets the requirements above; and
  - lives with you; and
  - receives principal support from you; and
  - is approved in Writing by Us as a Dependent Child.
- [- Your child 19 years but less than [25] years of age who otherwise qualifies above, if that child receives principal support from you and is a Full-Time Student, as defined.]
- [- Your child 19 years but less than [25] years of age, if that child is a Mormon Missionary [for a period of [two years] or less], and

- meets the requirements above; and
  - receives principal support from you].
- [ - Your Domestic Partner's child who otherwise qualifies above, or if you or your Domestic Partner has been appointed the child's guardian under a valid court order.]

Dependent Child will include any child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) as defined by applicable federal law and state insurance laws that are applicable to the Group Policy, provided the child meets the definition of a Dependent Child.]

**[Developmental Disability]** means a Dependent Child's substantial handicap which:

- results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder; and
- is diagnosed by a Physician as a permanent or long-term continuing condition.]

**[Domestic Partner]**

Your [opposite sex or] same sex life partner, provided:

- a. the partner is not in the armed forces of any country; and
- b. the partner is not covered under the Group Policy as a Member; and
- c. the partner is at least 18 years of age; and
- d. neither the partner nor you are married to other persons; and
- e. neither the partner nor you have had another Domestic Partner in the 6-month period preceding the date of the Signed Declaration of Domestic Partnership; and
- f. the partner is not a blood relative of yours; and
- g. the partner and you have shared the same residence for at least [six] consecutive months and continue to do so; and
- h. the partner and you are each other's sole life partner and intend to remain so indefinitely; and
- i. the partner and you are jointly responsible for each other's financial welfare; and
- j. the partner and you are not in their relationship solely for the purpose of obtaining insurance coverage.]

**Experimental or Investigational Measures** means any Treatment or Service, regardless of any claimed therapeutic value, not Generally Accepted by specialists in that particular field of medicine.

**Full-Time Employee** means any person who is regularly scheduled to work for the Policyholder for at least [30 hours] a week. The employee must be compensated by the Policyholder and either the employee or the employer must be able to show taxable income on federal or state tax forms. Work must be at the Policyholder's usual place or places of business or at another place to which an employee must travel to perform his or her regular duties.

An owner, proprietor or partner of the Policyholder's business will be deemed to be an employee for purposes of the Group Policy, provided he or she is regularly scheduled to work for the Policyholder for at least [30 hours] a week and otherwise meets the definition of Full-Time Employee.

**[Full-Time Student** means your Dependent Child attending a school that has a regular teaching staff, curriculum and student body and who:

- attends school on a full-time basis, as determined by the school's criteria; and
- is dependent on you for principal support.]

**Generally Accepted** means Treatment or Service for the particular sickness or injury which is the subject of the claim that:

- has been accepted as the standard of practice according to the prevailing opinion among experts as shown by (or in) articles published in authoritative, peer-reviewed medical and scientific literature; and
- is in general use in the relevant medical community; and
- is not under scientific testing or research.

**Group Health Plan** means an employee welfare benefit plan, as defined in ERISA, to the extent that the plan provides medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance reimbursement, or otherwise.

**Group Policy** means the policy of group insurance issued to the Policyholder by Us which describes benefits and provisions for insured Members [and Dependents].

**Health Care Extender** means a health care provider who assists in the delivery of covered medical services under the direction and supervision of a Physician.

"Direction and supervision" means the Physician co-signs any progress notes Written by the Health Care Extender; or there is a legal agreement that places overall responsibility for the Health Care Extender's services on the Physician.

**Health Insurance Coverage** means benefits consisting of medical care provided directly, through insurance or reimbursement or otherwise and including items and services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, or Health Maintenance Organization (HMO) contract, offered by an insurance company, insurance service, or insurance organization (including an HMO) licensed to engage in the business of insurance and subject to state law which regulates insurance.

**Health Maintenance Organization (HMO)** means an entity that is:

- a federally qualified Health Maintenance Organization as defined by federal law; or
- an organization recognized under state law as a Health Maintenance Organization; or
- a similar organization regulated under state law for solvency in the same manner and to the same extent as such a Health Maintenance Organization.

**HMO Affiliation Period** means a period of time which, under the terms of the Health Insurance Coverage offered by a Health Maintenance Organization (HMO), must expire before an individual's coverage becomes effective.

**Home Health Aide** means a person, other than a licensed registered nurse (R.N.), who provides medical or therapeutic care under the supervision of a Home Health Care Agency.

**Home Health Care Agency** means a Hospital, agency, or other service that is certified by the proper authority of the state in which it is located to provide home health care.

**Home Health Care Plan** means a program of home care that:

- is required as the result of a sickness or injury; and
- prevents, delays or shortens a Hospital Inpatient Confinement or Skilled Nursing Facility confinement; and
- is documented in a Written plan of care; and
- is prescribed by the attending Physician; and
- is preapproved by Us.

**Home Infusion Therapy Services** means Treatment or Service required for the administration of intravenous drugs or solutions, which:

- is required as a result of a sickness or injury; and
- prevents, delays, or shortens a Hospital Inpatient Confinement or Skilled Nursing Confinement; and
- is documented in a Written plan of care; and
- is prescribed by the attending Physician; and
- is preapproved by Us.

**Hospice** means a facility, agency, or service that:

- is licensed by the proper authority in the state in which it is located to establish and manage Hospice Care Programs; and

- arranges, coordinates, and provides Hospice Care Services for dying individuals and their families; and
- maintains records of Hospice Care Services provided and bills for such services on a consolidated basis.

**Hospice Care Program** means a program that furnishes palliative or supportive care focused on comfort and not cure and that is:

- managed by a Hospice; and
- established jointly by a Hospice, a Hospice Care Team, and an attending Physician;

to meet the special physical, psychological, and spiritual needs of dying individuals and their families.

**Hospice Care Team** means a group that provides coordinated Hospice Care Services and normally includes:

- a Physician;
- a patient care coordinator (Physician or nurse who serves as an intermediary between the program and the attending Physician);
- a nurse;
- a mental health specialist;
- a social worker;
- a chaplain; and
- lay volunteers.

**Hospital** means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, but not including any institution, or part thereof, that is used primarily as a clinic, Skilled Nursing Facility, convalescent home, rest home, home for the aged, nursing home, custodial care facility, or training center.

For the purpose of [Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services]/[*Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services*], the definition of "Hospital" will include each of the following facilities provided it is licensed by the proper authority of the state in which it is located:

- a Psychiatric Hospital; and
- an Inpatient Alcohol or Drug Abuse Treatment Facility; and
- any other facility required by state law to be recognized as a treatment facility under the Group Policy.

**Hospital Inpatient Confined; Hospital Inpatient Confinement** means any period of Treatment or Service in a Hospital in excess of 23 consecutive hours for any cause. A Hospital Admission Review [Prenotification] is required for all Hospital Inpatient Confinements.

**Hospital Inpatient Confinement Charges** mean Covered Charges by a Hospital for room, board, [and other usual services and by a Physician for pathology, radiology, or the administration of anesthesia] provided while a person is Hospital Inpatient Confined.

**Hospital Room Maximum** means Covered Charges by a Hospital for room and board while confined in a private room up to:

- the Hospital's most frequent semiprivate room rate if the Hospital has semiprivate rooms; or
- the Hospital's most frequent private room rate, if the Hospital has no semiprivate rooms.

**Immediate Family** means [your Domestic Partner or] an insured person's spouse, natural or adoptive parent, natural or adoptive child, sibling, stepparent, stepchild, stepbrother or stepsister, father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law, grandparent, grandchild or spouse of grandparent or grandchild.

**Inpatient Alcohol or Drug Abuse Treatment Facility** means an institution that is licensed by the proper authority of the state in which it is located and is primarily engaged in providing alcohol or drug detoxification or rehabilitation treatment services and;

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.); and
- provides 24-hour a day on-site nursing care by licensed registered nurses (RNs).

**Medical Emergency** means any Treatment or Service that We determine to be due to the sudden onset of severe medical symptoms that:

- could not have been reasonably anticipated; and
- requires immediate medical care.

**Member** means [any person who is a Full-Time Employee of the Policyholder.]

[Member will also include any such person who retires on or after [August 1, 2001] and maintains continuous coverage with the Policyholder under the Group Policy.]

**[Mental Health or Behavioral Treatment Services]** means Treatment or Service provided to alter a person's behavior regardless of the cause of that behavior, including but not limited to: individual, family or group psychotherapy; psychological testing; electroconvulsive therapy; psychiatric diagnostic interviews or examinations; behavior modification; psychiatric medication management; [hypnotherapy;] narcosynthesis; [biofeedback;] or milieu or other therapies (physical, occupational or speech therapy), used to diagnose or treat mental health or behavioral problems.]



***[Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services means Treatment or Service provided to alter a person's behavior, regardless of the cause of that behavior, including, but not limited to: individual, family or group psychotherapy; psychological testing; electroconvulsive therapy; psychiatric diagnostic interviews or examinations; behavior modification; psychiatric, alcohol or drug abuse medication management; alcohol or drug abuse rehabilitation or counseling services; [hypnotherapy]; narcosynthesis; [biofeedback], milieu or other therapies (physical, occupational or speech therapy) used to diagnose or treat mental health, behavioral, alcohol or drug abuse problems.]***

**[Non-Preferred Provider/Non-PPO Provider** means a Hospital, Physician, or other provider not contracted with the Preferred Provider Organization (PPO) network established by [John Doe PPO].]

**[Outpatient Alcohol or Drug Abuse Treatment Facility** means a facility that is licensed by the proper authority of the state in which it is located, and is primarily engaged in providing outpatient alcohol or drug abuse treatment services.]

**[Period of Confinement** means a period of Hospital Inpatient Confinement. For the purposes of applying the Hospital charges Copay amount for each admission, two or more periods of Hospital Inpatient Confinement will be considered one period of confinement unless caused by an unrelated sickness or injury, or unless separated by [30 consecutive] days or more.]

**[Physical Handicap** means a Dependent Child's substantial physical or mental impairment which:

- results from injury, accident, congenital defect or sickness; and
- is diagnosed by a Physician as a permanent or long-term dysfunction or malformation of the body.]

**Physician** means:

- a licensed Doctor of Medicine (M.D.) or Osteopathy (D.O.); or
- any other licensed health care practitioner that state law requires be recognized as a Physician under the Group Policy.

Whether or not required by state law, the following licensed or certified health care practitioners will be recognized, on the same basis as a Physician, for Covered Charges of services performed within the scope of their license: audiologist, chiropractor, dentist, [genetic counselor,] occupational therapist, optometrist, physician's assistant, physical therapist, podiatrist, psychologist, social worker, and speech pathologist.

**Physician Visit** means a face-to-face meeting [or an approved form of on-line consultation] between a Physician or the Physician's staff and a patient for the purpose of medical Treatment or Service.

**[Physician Visit Charges** mean Covered Charges for Treatment or Services furnished at a Physician's office or clinic. Such services include charges for: dressings; [supplies;] [equipment;] injections; anesthesia; take-home drugs; blood; blood plasma; x-ray and laboratory examinations; x-ray, radium, and radioactive isotope therapy; and routine physical

examinations[; but do not include outpatient, clinic or office-based surgery magnetic resonance imaging (MRIs); computerized axial tomography (CATs); and positron emission tomography (PETs) and single photon emission computerized tomography (SPECTs) or other similar imaging tests.]

**Placement for Adoption; Placement** means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of adopting the child. The child's placement with the person terminates upon the termination of such legal obligation.

**Policyholder** means [John Doe Company] [and shall include any affiliate or subsidiary of the Policyholder participating under the Group Policy].

**[Preferred Provider/PPO Provider]** means a Hospital, Physician, or other provider contracted within the Preferred Provider Organization (PPO) network established by [John Doe PPO].

The Policyholder's participation in the PPO network does not mean that an insured person's choice of provider will be restricted. The insured person may seek needed medical care from any Hospital, Physician, or other provider of his or her choice. However, in order to avoid higher charges and reduced benefit payment, the insured persons are urged to obtain such care from Preferred Providers whenever possible.

We have the right to terminate the PPO portion of the Group Policy if We or the PPO terminates the arrangement.

We also have the right to identify different Preferred Provider Organizations from time to time, and to terminate the designation of any Preferred Provider at any time.]

**[Preferred Provider Organization (PPO)]** means [John Doe PPO].]

**[Preferred Provider Organization (PPO) Service Area]** means the geographic area within which Preferred Provider services are available to persons insured under the Group Policy.]

**[Prevailing Charges means:**

- For medical care received from Preferred Providers, the amount based on the negotiated fee between the Provider and the PPO.
- [- For medical care received from Non-Preferred Providers, the amount, as determined by Us, that most healthcare providers charge within a geographic cost area for a Treatment or Service.

For purposes of coverage provided under the Group Policy, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by Us, [75%] or more of all other charges reported to Us for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.]

- [- For medical care received from Non-Preferred Providers, the amount as determined by Us that is derived from a cost-based methodology used by Medicare or a methodology similar to one used by Medicare.]

[For Home Infusion Therapy Services, the amount will be established by Us at the time services are preapproved, not to exceed the Average Wholesale Price.]

[For medical care received from a Transplant Network Provider, the amount will be based on the negotiated fee.]

[For drugs and medicines requiring a Physician's prescription and considered a covered Treatment or Service, Prevailing Charges will not exceed the Average Wholesale Price.]

- [- For purposes of Treatment or Service for a Medical Emergency provided outside the United States, the Prevailing Charge will be calculated based on the [Policyholder's] [Participating Unit's] United States Address.]

**[Prevailing Charges means:**

- As determined by Us, the amount that most healthcare providers charge within a geographic cost area for a Treatment or Service.
- For purposes of coverage provided under the Group Policy, an actual charge for a Treatment or Service will be in excess of Prevailing Charges if, as determined by Us, [80%] or more of all other charges reported to Us for the same (or a similar) Treatment or Service provided within the same (or a comparable) cost area are lower in amount than the actual charge.]
- [- For medical care received, the amount as determined by Us that is derived from a cost-based methodology used by Medicare or a methodology similar to one used by Medicare.]
- [For Home Infusion Therapy Services, the amount will be established by Us at the time services are preapproved, not to exceed the Average Wholesale Price.]

- [For medical care received from a Transplant Network Provider, the amount will be based on the negotiated fee.]
- [For drugs and medicines requiring a Physician's prescription and considered a covered Treatment or Service, Prevailing Charges will not exceed the Average Wholesale Price.]
- [- For purposes of Treatment or Service for a Medical Emergency provided outside the United States, the Prevailing Charge will be calculated based on the [Policyholder's] [Participating Unit's] United States Address.]

**[Primary Care Physician]** means a Physician who is a family or general practitioner, internist, obstetrician/gynecologist or pediatrician.]

**[Psychiatric Hospital]** means an institution that is licensed as a Hospital by the proper authority of the state in which it is located, and is primarily engaged in providing diagnostic and therapeutic [Mental Health or Behavioral Treatment Services]/*[Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]*.

For the purpose of this definition, a Psychiatric Hospital will also include any inpatient bed in a licensed general Hospital used to provide diagnostic and therapeutic [Mental Health or Behavioral Treatment Services]/*[Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]* in the absence of a specialized or designated psychiatric or drug treatment unit.]

**Signed or Signature** means any symbol or method executed or adopted by a person with the present intention to authenticate a record, and which is on or transmitted by paper or electronic media, and which is consistent with applicable law and is agreed to by The Principal.

**Skilled Nursing Facility** means an institution (including one providing sub-acute care), or a distinct part thereof, that is licensed by the proper authority of the state in which it is located to provide skilled nursing care and that:

- is supervised on a full-time basis by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) or a licensed registered nurse (R.N.); and
- has transfer arrangements with one or more Hospitals, a utilization review plan, and operating policies developed and monitored by a professional group that includes at least one M.D. or D.O.; and
- has an existing contract for the services of an M.D. or D.O., maintains daily records on each patient, and is equipped to dispense and administer drugs; and
- provides 24-hour nursing care and other medical treatment.

Not included are rest homes, homes for the aged, nursing homes, or places which furnish [Mental Health or Behavioral Treatment Services and Alcohol or Drug Abuse Treatment Services]/*[Mental Health, Behavioral, Alcohol or Drug Abuse Treatment Services]*.

**[Specialty Provider]** means any Physician other than a Primary Care Physician who is classified as a specialist by the American Boards of Medical Specialties; or who is designated by the Group Policy as a Specialty Provider.]

**[Temporomandibular Services]** means any Treatment or Service to diagnose, prevent, or correct malfunction, degeneration, disease, injury, and all other ailments or defects (congenital or hereditary) related to the joints, muscles, and tissues that connect the jaw to the skull.]

**[Total Disability; Totally Disabled]** means:

- For a Member [(other than a retired Member)], a Member's inability, as determined by Us, due to sickness or injury, to work at any job that reasonably fits his or her background or training.
- For [a Dependent] [or a retired Member], a substantial impairment, due to sickness or injury, that prevents the individual from performing the normal function of his or her regular duties or activities.]

**[Transplant Network]** means any network of providers We determine to be an appropriate transplant network and that has contracted to provide Transplant Services subject to a negotiated fee schedule as shown in this booklet.] The Transplant Network is [United Resource Networks.]]

**Treatment or Service**, when used in this booklet, will be considered to mean: "confinement, treatment, service, substance, material or device".

**Waiting Period** means, with respect to a Group Health Plan and an individual who is a potential enrollee in the plan, the period of time that must pass with respect to the individual before he or she is eligible to be covered for benefits under the terms of the plan.

[The Waiting Period for your coverage [and the coverage of your eligible Dependents] under the Group Policy is [three consecutive months] of continuous employment as a Member, as described in GH 115 A (MED).]

**We, Us, and Our** mean Principal Life Insurance Company, Des Moines, Iowa.

**Written or Writing** means a record which is on or transmitted by paper or electronic media, and which is consistent with applicable law.

<i>SERFF Tracking Number:</i>	<i>PRLF-126079005</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>Principal Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>41963</i>
<i>Company Tracking Number:</i>			
<i>TOI:</i>	<i>H16G Group Health - Major Medical</i>	<i>Sub-TOI:</i>	<i>H16G.001C Any Size Group - Other</i>
<i>Product Name:</i>	<i>GC 5000, et al</i>		
<i>Project Name/Number:</i>	<i>Lg Employer MHAD/</i>		

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: PRLF-126079005 State: Arkansas  
Filing Company: Principal Life Insurance Company State Tracking Number: 41963  
Company Tracking Number:  
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001C Any Size Group - Other  
Product Name: GC 5000, et al  
Project Name/Number: Lg Employer MHAD/

## Supporting Document Schedules

**Review Status:**  
**Satisfied -Name:** Flesch Certification Approved-Closed 03/25/2009  
**Comments:**  
**Attachment:**  
Certification of Readability.pdf

**Review Status:**  
**Bypassed -Name:** Application Approved-Closed 03/25/2009  
**Bypass Reason:** Our employer application form is not being revised. Our employer application form that is currently being used, form number GP 45697-6, was approved by the Arkansas Department of Insurance on October 27, 2008.  
**Comments:**

**Review Status:**  
**Satisfied -Name:** Statement of Variability Approved-Closed 03/25/2009  
**Comments:**  
**Attachment:**  
Statement of Variability.pdf

**STATE OF ARKANSAS  
INSURANCE DEPARTMENT**

**CERTIFICATION OF READABILITY**

I, Mark L. Hill, an Officer of Principal Life Insurance Company hereby certify that the attached form(s) has (have) achieved a Flesch Reading Ease Score of:

Form No.	Form Name	Flesch Score
GC 5000, et al	Group Medical Expense Insurance Policy Forms	50
GH 100, et al	Group Medical Expense Insurance Booklet-Certificate Forms	50

and complies with the requirements of Ark. Stat. Ann. Sections 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

PRINCIPAL LIFE INSURANCE COMPANY



Mark L. Hill, Director  
Group Life and Health Compliance

March 24, 2009  
Date

12/1999





**STATEMENT OF VARIABILITY FOR ARKANSAS SAAO MENTAL HEALTH  
AND ALCOHOL OR DRUG ABUSE FILING**

- [1] Use for small employer groups that employed an average of at least two but not more than 50 employees on business days during the preceding calendar year, and that employs at least two employees on the first day of the plan year.
- [2] Use for large employer groups that employed an average of at least 51 employees on business days during the previous calendar year.